# The Public Health Nurse

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## Public Health Nurses in Civil Service

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## Combining Against Tuberculosis

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## Public Health Nursing Services Defined

# *The* PUBLIC HEALTH NURSE

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## WHEN THE DOCTOR SAYS "IT IS NOTHING"

*Foreword:* In connection with the educational campaign being waged against cancer—who hasn't seen the flaming sword, "Fight Cancer with Knowledge," on the billboards?—we are glad to print this editorial from one of the medical profession.

Let us suppose your patient tells you that she has a small lump in her breast, or that her father has had a sore on his lip for the past six weeks which has healed and reopened again from time to time, or that her mother, who had her change of life four or five years ago, has recently noticed spotting again, and that the doctor consulted, perhaps the only physician in the village, has said "it is nothing, forget about it." In such a case the thought will persist in your mind, in spite of the doctor's advice, that the condition in question may be cancer. You know that the longer a cancer is left growing the poorer are the patient's chances of escape. You feel, and you are right, that human life is at stake, because while the condition may not be cancer, yet if it *is*, priceless time is being lost.

If a patient is not entirely satisfied with one doctor's opinion, he is perfectly justified in seeking a second or even a third opinion. In this day of easy transportation there is no reason why the patient cannot arrange to see a leading surgeon in some nearby city in order to be sure of the diagnosis. For those who cannot afford to pay a consultation fee, the out-patient department of some good medical school or hospital affords a reliable source of information. Perhaps before a positive diagnosis can be made it may be necessary to remove a small piece of the diseased region for microscopical examination. If this is done, and the condition proves to be cancer, not more than three or four days should elapse before complete removal because the growth of a cancer is accelerated by any injury to it. At every first-class hospital a pathologist is available while operations on cancer patients are going on. If a condition found by the surgeon is suspected of being cancerous, a piece of tissue is removed and immediately given to the pathologist who makes a frozen section at once, stains it, and examines it with a microscope. The character and extent of the operation depend upon his report. Thus, no time is lost between diagnostic removal and adequate surgical treatment.

Dr. Bloodgood of Johns Hopkins has stated that the diagnosis of small tumors has ceased to be clinical and has become microscopical. Patients with tumors in very early stages are coming to the surgeons in increasing numbers, and the true character of the growth must rest on microscopical examination. When a clinical diagnosis can be made without doubt, it is often because the condition is so far advanced that treatment cannot be effectual.

One swallow does not make a summer and one medical diagnosis may not be entirely satisfactory. Where so fatal a condition as cancer is suspected, no stone should be left unturned to make sure about the exact nature of the condition under suspicion.

# The Philosophy of Education Applied to Staff Education for Public Health Nurses

By Katharine Faville, R.N.

PHILOSOPHY holds the attainment of the "good life" as the goal of human endeavor, and defines its characteristics in terms of individual growth which continues so long as life endures. Since work consumes at least one-third of all our time, no life can be "good" in which the work itself does not contribute to the individual's growth. Only such work as holds the interest, giving opportunity for some expression of the worker's creative ability, which has that quality of leading on to more and larger interests, is a part of the "good" life.

Education, as philosophy views it, is not a thing apart, a preparation for existence at some future time, but is life itself as it is lived day by day. Where we find the "good life" we find education "good," productive of continuous growth of the individual—spiritual, intellectual, physical. Our answer to the question "what is life" determines the kind of education for us to strive for.

Nothing is so certain in this world as that change is constant—though we see it as a world of continuity its elements are forever variable. Any adequate educational program, therefore, should strive to help its students live more wisely in such a changing world, giving them an ability to think and reason, to evaluate and adapt themselves to it, since change itself is inevitable.

We hear much these days about "machine civilization." With the ascendancy of the machine has come, too, a desire for standardization, for routine and uniformity, for similarity of thought as well as of technique. Though we may differ as to the detailed constituents of the "good life" and what path to travel in its attainment, most of us will agree that it is not obtained through "machine" thinking, while opportunity for creative self-expression does much to bring it within reach. Rugg and Shumaker, in their book "The Child Centered School," say:

"The concepts of the creative mind contrast sharply with those of the imitative exploitive mind. Note, for example, the confident affirmation of the importance of self in place of that of conformity and inferiority; the emphasis upon integration, upon uniqueness, instead of analysis, standardization, and uniformity; the concept of technique as the efficient servant of vision—technique as means rather than as the masterful end."

### *Education on the Job*

Recently the attention of public health nurses has turned to the development of programs of staff education, but the amount of public money being expended would warrant more thoughtful consideration of the principles underlying such development than apparently is being given. Since it seems impossible at present to fill all positions with nurses who have had previous public health training, it is necessary for many nurses to learn "on the job." Obviously, then, the first objective of any staff education program is to initiate these new nurses into the policies and the field practices of the organization, with the accompanying purpose of keeping them—once trained—aware of all the new developments in public health.

But are these educational programs developed in answer to the question "what is life"—that part of life, at least, that our public health nurses live during their working hours and with which staff education is concerned? If they are, then several facts are self-evident.

Since change is as apparent in the

development of public health nursing as it is in any other phase of life, any program of education for public health nurses, to be permanently effective, must accept the inevitableness of change as the basis of all its teaching. How many of our staff education programs really help nurses to live more wisely within this constantly changing profession, teaching them to think and reason as to cause and effect, to recognize and apply basic principles, to evaluate change as well as adapt to it, accepting today's practice as the best we know today, and tomorrow's revisions with equal understanding?

*Need for the Creative Mind*

No profession has greater need for the creative mind, no profession should be able to offer greater outlet for creative self-expression and leadership than that of public health nursing. Is our staff education planned so that every spark of the creative mind is prized and developed, so that the spirit of scientific curiosity pervades all our work; or are we teaching routines and techniques in such fashion that they become the "masterful end" instead of the "efficient servant of vision"? Should public health nursing practice be alike from coast to coast, or should we strive for services as variable as communities and their needs are variable?

The measure of the results of our staff education programs is found most obviously in the quality of service our staff nurses render, but equally so in their attitudes towards life during their on-duty time, in the joy of living they derive from the adventures of their day's work. Is each staff nurse growing "on the job"? Is each so intensely interested in the long path ahead, as she visions it, that the future is at least as full of promise as the present? Does the day's work for her possess "leading on" values that bridge the passage of one day to the next? Does experimentation with the way of doing the day's work meet with approbation or a frown? Does the staff as a staff welcome change as that element which brings spice to life, or as a group do they resent and fight against anything that means temporarily upset programs, more work, a jolt from the comfortable ruts of routine?

*Professional Growth*

Are young leaders rising from the ranks, responsible, able, thoughtful, so that the staff is looked upon as the most certain place in which to gain professional growth?

When will the staff nurse come into her own, so that her work is recognized and acclaimed as the very foundation stone of public health nursing? When will it be possible for a staff nurse to stay a staff nurse for ten, or fifteen, or twenty years, and have each day of those years give her growth in professional wisdom, in spiritual and intellectual values? When will the seasoned, valued staff nurse be paid as much—for example—as a young, perhaps inefficient supervisor? When will promotion cease to be measured only in terms of supervisory or administrative functions, and due recognition given to the person whose talent and joy lies in direct service to her families?

Not, probably, until those who plan for staff education themselves become more conscious of the satisfactions possible in staff work, until they view education as life and not preparation for it, until they, with the philosopher, cherish a vision of the "good life" as the goal of each individual; measuring the "good" in terms of growth continuous to the end of life, and treasuring the creative mind as the spark of life without which the spirit smoulders and dies.

# The Joint Council on Community Nursing

DETROIT, MICHIGAN

IN Detroit during the days of the War, there were several organizations with the one common objective—nursing the community. The necessity of having a central headquarters for all nursing activities was realized and the Visiting Nurse Association offered space as headquarters. During the next few years the nursing activities of the city had so enlarged that the Central Bureau of Nursing was formed under the direction of a representative committee.

The Bureau, acting as an advisory committee, in no way interfered with the autonomy of the individual organizations. Its aims were:

To give to the public a nursing service of the highest standards.
To provide nursing care to meet the needs of all.
To become a bureau of information and counsel.
To become an educational and social center for every phase of nursing.
To establish a clubhouse to meet these needs.

With countrywide studies of nursing under way, the Central Bureau of Nursing felt the need for self-analysis in order to determine what its service to the community should be; also the need for studying its community in the light of what was being done and what should be done to provide adequate nursing.

With this in mind the name of the Bureau was changed in 1928 to The Joint Council on Community Nursing.

"I can foresee in the future," said Dr. Winslow, "that in every well ordered community there will be a Joint Council on Community Nursing which will include representatives of hospitals and training schools, of official and voluntary public health nursing organizations, and of the registries which will make continuing studies of these problems and will strive to solve them through joint effort for the common good."

Representatives from the following organizations now make up the Joint Council on Community Nursing:

Wayne County Medical Society
Detroit Community Union
Visiting Nurse Association
Tuberculosis Society
Detroit Federation of Women's Clubs
Department of Education
Department of Health
Merrill-Palmer School
American Red Cross
Detroit District, M.S.N.A.
Visiting Housekeeper Association
Detroit League of Nursing Education
University of Michigan
Michigan State Nurses Association
International Institute
The Children's Aid Society
Lay members, representing the general public.

The Council meets once a month and hears reports from its committees on Education (responsible for the course in public health nursing and for a teaching center for students and staff nurses in public health), Practical Nursing, Hourly Nursing, Publicity and other professional activities.

The Council has taken its function to be:

1. To serve as a means whereby the various organizations in the community concerned with nursing together with representatives of the general public may jointly consider the problem of nursing education and may assist in promoting in Detroit an educational program for the young woman entering the nursing profession which will prepare them to give the highest type of nursing service in whatever field they may enter.

2. To serve as a means whereby they may also study the nursing needs of the city and may assist in establishing or promoting those types of service which the city needs in such a way as to insure efficient service to every citizen who needs nursing care of any sort.

# Application of the Principles of Social Case Work to Public Health Nursing *

By Virginia Robinson
Associate Director, Pennsylvania School of Social and Health Work, Philadelphia, Pa.

SOCIAL case work in the United States with some fifty years of history behind it, seems to have followed a somewhat different trend of development from its development in other countries. Its present position in 1929 is difficult to describe since it is in a condition of such rapid and revolutionary movement in respect to purposes, aims, and methods. Its philosophy reveals the effects of the unsolved conflict so disturbing to all scientific thought today between the older allegiance to scientific cause and effect and the newer concepts of relativity, *i.e.*, that cause and effect are not absolute but are relative questions. The contributions of psychiatry to the understanding of cause and effect in human behavior have not yet been assimilated into case work before the dynamic concept of the "transfer," from psychoanalytic therapy, disturbingly invades the treatment relationship. All of this influence is in the air but not yet assimilated into case work thinking and practice to the point where it can be said "This is social case work." Again, we are differentiated tremendously in this country by the variations in the social problem as it emerges in different geographical areas. From the larger experimental areas of the cities of the eastern seaboard to the rural counties in remote, isolated sections of the country, we may find a difference of half a century in the definition of the case work job.

### PHASES OF DEVELOPMENT

We can describe two phases in the development of the social case work movement in this country, which for convenience may be named, a sociological and a psychological phase. In the United States as elsewhere this movement grew out of a very simple human effort to alleviate some of the sufferings of humanity. These sufferings were approached first environmentally, so that case work appeared in organized forms around what were thought to be environmental causes of human failure. Particularly at first, case work developed around the crying problems of poverty and sickness. In the fifty years development of the charity organization movement which may be taken as illustrative of case work in general, two things have characterized it steadily. First, a constant undeviating insistence upon attacking the problem of poverty, individual case by individual case, and second, the development of more generalized ways of dealing with this problem. This trend which we may call sociological, still continues within the case work movement, as general causes are isolated and national agencies built up to take over the responsibility for treatment; but the case work movement tends to throw off from itself, as it were, the responsibility for this type of treatment as soon as other agencies will assume it.

Along with the recognition of common, fundamental, environmental factors, which can be dealt with as such, frequently by public means, there has always remained in the case work movement, unfailing insight into the peculiar unique characteristics of every case which presented itself as unlike every other, necessitating therefore individual and different treatment methods in each situation. These individual differences have been variously interpreted as our knowledge of psy-

* Paper presented at the International Council of Nurses, Montreal, July, 1929.

chology has increased and deepened, from the fixed inherited character differences of 1900–1910 to the more modifiable conditioned bases of difference of today, but throughout, regardless of interpretation, it is the same problem which has absorbed and held the case worker—*the problem of understanding and treating the individual.* This interest has determined the psychological phase of case work which is becoming increasingly emphasized today.

#### EXAMPLE OF PRESENT DAY CASE WORK

May I take the problem of feeblemindedness to illustrate this difference? We deal here with a problem which springs from many roots in social situations and can be dealt with first on an environmental level. For effective treatment of this problem in any community, we understand first the causes of feeblemindedness and bring to bear any controls which may have been established in prevention. Secondly, we work through clinics which examine and measure the educational capacity of the defective, through special classes or schools equipped to give training adapted to the needs of each level of ability, through institutions for custodial and educational purposes. Each problem when diagnosed in respect to its intelligence equipment may fall into a definite, well defined category for which stereotyped treatment may be found, but over and above this definite factor, there remains always the individual's peculiar behavior patterns, his emotional reactions, his ways of relating himself to other people and to his environment. So that in undertaking the problem of a feebleminded child, the social case worker builds upon these known general sociological factors, makes use of the standardized treatment agencies in the environment, but in addition, is increasingly intrigued by the unique nature of the child's behavior picture, his personality make-up, his adjustment capacity. In this aspect the problem is psychological. In such a relationship as this, anti-social behavior symptoms may disappear, destructive personality traits modify into more constructive traits, and an adjustment capacity develops. A great deal has been learned since the war, when psychiatry allied itself with social case work, more even in the past five years, through the activities of the Child Guidance Clinics, about the history and causative factors in behavior and personality development. Very little is known as yet about the dynamics and potentialities of the treatment relationship. With this problem, psychiatrists and social case workers will be occupied for many years to come.

#### APPLICATION TO PUBLIC HEALTH NURSING

It is at this point, it seems to me, that the application of social case work principles to the field of public health nursing may be helpfully made. The public health nurse, like the social case worker, is working in a field where certain problems have been handled to the point where general causes are known and where treatment agencies have been successfully developed. The public health nurse, like the social case worker, must be familiar with these sociological causative factors and treatment possibilities. In many respects her health problems will present social aspects with which social agencies have been organized to deal, and she will need to know how to work with these coöperatively and effectively. But in other aspects of the contact with the public health problem, it presents itself in as individual and unique a manner as it does to the social case worker. Here it is the individual patient, his attitudes, his needs, his emotional reactions which determine the effectiveness of any treatment. The tubercular man for whom sanatorium treatment is indicated defies the correct social and health plan of the public health nurse or social case worker successfully when he refuses to go away from his family, or returns unexpectedly and inexplicably after a week's stay in a good sanatorium. Again, a pregnant woman, for whom treatment is laid out in clinic and hospital through the nurse

and doctor, may defeat the whole plan by a blind fear and refusal to follow the prescribed course. The public health nurse must meet again and again in her daily job the factor of individual difference and her success depends upon her capacity to understand and work with this factor. In the day of any nurse who handles mothers—the private duty nurse, the hospital nurse or the nurse doing any type of public health work—the health problem presents itself always in individual terms. She may know that tonsils should come out, that glasses should go on, but how to achieve the result with the least damage to the child, to the mother, and other members of the family is a very different problem.

### THE FACTORS OF INDIVIDUAL DIFFERENCE

Every nurse who is working directly with people in private or public health service is dealing with the same factors of individual difference and with the dynamics of relationship with which social case work is absorbed. Often she deals more effectively, at least to immediate appearances than the social case worker. Usually she deals more intuitively and less consciously. I say she deals more intuitively because the nurse brings to her health problem understanding and acceptance of it, based on previous knowledge and experience and inspires confidence and assurance in her patient in proportion to this understanding. As long as the point of contact remains on a health problem, where the nurse's equipment is assured, her effectiveness with the client is apt to be greater than the case worker's, who must establish slowly a confidence the nurse achieves by virtue of her title and her uniform. But in the field of behavior, so inseparable from health, where the nurse has little knowledge and correspondingly little capacity for acceptance of differences in behavior, her success in dealing with individual difference is far less assured. An illustration might be taken from the daily job of the school nurse.

The school nurse visits the home to discuss with the mother an obvious health problem—the poor eye sight and need for glasses of her child. The mother accepts the nurse's knowledge and experience in this field and presents to her other problems which seem to her as crucial in the child's development, possibly a problem of enuresis or masturbation, of jealousy or temper. It is not possible to expect the mother to make a separation among these problems. She needs help perhaps even more with the behavior difficulties. Frequently it is not possible to ask her to go to another worker or another agency. The school nurse may already have a contact with her which another worker would strive long to attain, and again there may be no organized agency in the community for working with behavior difficulties.

It would seem almost essential for the nurse faced with these problems to respond with some attitudes which would be helpful to the mother in dealing with her child. The question which presents itself is how much can we expect the nurse, who must be equipped with all the knowledge relating to health problems, to acquire also sufficient understanding of behavior difficulties and personality problems to deal constructively with mothers in this type of problem? We see case workers and psychiatrists spending their lives in an effort to gain more and more understanding into these psychological problems. We cannot ask the nurse with other primary responsibilities to take over to this same extent, an interest in and responsibility for psychological knowledge.

### EXPERIENCING ATTITUDES

I am wondering, however, if we cannot expect as part of her professional development, some progress in acquiring the attitudes to which I have referred before—the attitudes of understanding and acceptance of various kinds of behavior without criticism? This is impossible, of course, without psychological knowledge, but I think it is possible with a limited amount of psychological knowledge. Very inter-

esting parallels present themselves in the field of parental education. In this field a great effort is being made to give over to parents sufficient psychological point of view to enable them to deal with the problems which arise in the relationships with their children more intelligently. No effort is made to make of parents psychiatrists or social case workers, who would be able to go out and diagnose and treat problems of individual children in other families, but it is astonishing to discover that often a very little insight may make for a very great change of attitude in relation to a child and operate constructively for the child.

Again, the same factors which we have found to be effective in the case work approach to the client's problem are the ones which are effective in the parents' attitude towards the child. If the parent can take an understanding attitude toward the child's problem rather than a critical, judgmental, punishing one, the problem is often on its way to solution. If he can accept the child's attitude or behavior as not strange, peculiar, reprehensible, but natural and understandable, frequently the child no longer needs the attitude or behavior and can give it up for a more positive, satisfactory type of attitude or behavior. Again, in the saying, these factors seem simple or perhaps vague and intangible. In practice they show themselves to be amazingly dynamic and creative of change.

There is no way of learning these attitudes verbally as one acquires factual knowledge. Attitudes must be lived and experienced in order to become a part of one's equipment. Both the case worker and the public health nurse, it seems to me, must begin to develop these attitudes in their training through field-work experience in which they have the opportunity for coming in contact with varieties of different experiences, and learn to know these not merely as different from their own, but as important, interesting, and significant in themselves. In discussion classes in the field of behavior and personality difference also, the public health nurse as well as the social case worker should have training in learning to understand and accept various kinds of behavior.

### TRANSCENDING LIMITS

Five years ago, perhaps, we taught the public health nurse and the social case worker to coöperate with each other, outlining as carefully as possible their respective fields. Today, it seems to me, through the development in both these fields, these limits are being more and more transcended through this increasing concern with the individual's problem. Whenever that problem presents itself to any agency, there it must be handled with the best equipment which the worker and that agency can acquire. Whether it be the teacher in the class room, the nurse in the clinic, the case worker in a social agency, or the psychiatrist in the clinic, who receives the problem, we should expect of their position which carries responsibility for dealing with people, a response to any human problem which is sufficiently understanding to be constructive for the individual presenting it. Furthermore, in more complex problems where the worker's knowledge is not adequate, it should at least be extended far enough to be able to guide the individual to a place where he will find greater help in the solution of his problem if he so desires.

We learn more and more with the years that only the individual himself can solve his own problem. Perhaps if there is any one principle the social case worker can pass on to the public health nurse from her experience it is this—a caution against attempting to solve the individual's problem for him.

# "The Badge of Service"

By Margaret Reid, R.N.

"WE'LL have help there in half an hour. I'll get Miss O'Brien." Mr. Steele, chairman of the Miami County Chapter of the American Red Cross, hung up the telephone receiver. "John, there's been an explosion at the Cooper Mine. Fifty men entombed! That's all we know except that the Red Cross must get into action at once. Call Mr. Cooley, our Disaster Chairman. He will get the different committees working. I'll 'phone Miss O'Brien. Thank God, we have at least one nurse in this county!"

In less than ten minutes Mr. Spooner, principal of the Foxrun School, ran down the hall to Miss Lockwood's room where she was assisting Miss O'Brien, the county nurse, in the health inspection of the children. Calling Miss O'Brien aside he told her of the accident.

"It couldn't be farther away, but if you take the 'Under the Mountain Road' you might make it in twenty minutes. It's about fifteen miles that way. You'll have to drive like mad. I guess you are needed pretty badly."

Stopping for nothing except the school's first aid kit Miss O'Brien jumped into the Ford, stepped on the gas and was off—off hurtling and bouncing over a road treacherously gutted and softened by recent Spring freshets.

As the Ford tore into the small mining town Miss O'Brien felt the frightened, expectant silence that hovered over the place. Doors stood ajar as they do when flung open by people leaving in frantic haste. The bank and stores were empty—some of them wide open, others closed and locked up. Old people with small children clinging to them were gazing anxiously toward the end of town where the Cooper Coal Mine was located. The rest of the people were at the mine. Wives and older children stood about. Some in stolid resignation—they had lived through mine disasters before. Others were weeping hysterically. All brightened a bit as Miss O'Brien jerked her car to an abrupt stop, for she was an old friend. As school nurse, they had learned to love and respect her—to follow her advice. Then, too, with her coming they remembered that the Red Cross had come to aid them in this terrible emergency. Was not that the Red Cross emblem on her hat, on her sleeve and on the door of the car?

In the sudden hush that her coming had produced Miss O'Brien walked calmly but quickly to the entrance of the mine. The foreman was at her side at once.

"You are wanted down in the mine," he said. "Doctor Miles went down the shaft the last trip before the elevator broke. We'll have to lower you. Oh, Nurse, you can't get down there quick enough! We knew you would come."

Thirty or forty feet Miss O'Brien was lowered into the black shaft hole by means of a hastily constructed swing. Down, down, down! The blackness seemed to be rushing up to meet the light. Suddenly, she was engulfed in it—voices from below reassured her—a flashlight gleamed and welcoming hands received her. In the dimness shadowy forms lay stretched on the floor of the mine, row upon row. Out of the yawning black tunnels men with pinched, determined faces were bringing limp figures in what seemed an endless chain. The rescue squad was in action. Accustomed to the darkness they handled the injured with amazing sureness. Back and forth they went—over and over again.

"Make the men as comfortable as you can. That's all we can do now." Doctor Miles passed his hypodermic outfit to her. "I can manage the dressings as the men are brought in. I'll call when I need your help."

With steady, deft hand Miss

O'Brien passed from one miner to the other. Here and there one would thank her with a brave smile but most of them were suffering too much to heed what she was doing. Those who seemed to be less seriously injured refused help, waving her on to the others. The atmosphere of long frightful waiting became more and more oppressive. The daylight and the outside world seemed miles and miles away. Hours were passing when minutes meant either life or death to these men, and food and happiness to the loved ones waiting above. How terrible the suspense of waiting must be to them.

*Courtesy of American Red Cross*

*Transportation of injured miner on improvised stretcher*

Again Miss O'Brien made her rounds—elevating an injured leg here, securing a bandage there. Coats had become pillows for bruised heads, slings for broken arms and coverings for the dying. Surely the men above did not realize the horrible state of the miners, the extent of the accident, or they would speed up the repair of the elevator. Miss O'Brien realized that the damp dark mine with its black glistening walls dripping moisture was "getting on her nerves." She must do something. The men of the rescue squad were standing by — waiting. Long since they had made their last trip into the tunnels. With one of them she made the rounds of the injured, giving the thirsty ones water. A drink seemed to give them new strength and courage.

Reassuring the miners renewed her own courage. She stopped to listen. In the distance the faint tap of hammers could be heard—thump, thump, thump. Then suddenly, out of the entrance tunnel emerged the foreman. The elevator was repaired. The long vigil was almost over. While Doctor Miles went up to direct the removal of the men to the hospital, to their homes or to the undertaker's, Miss O'Brien remained below to direct the removal of the injured to the elevator.

What a different sight greeted her at the entrance to the mine as she finally stepped out into the afternoon light. The Red Cross had been carrying on above ground as she, the Red

Cross County Nurse, had been doing below. Wives and mothers had been sent home as their men had been brought up from the mine. Only a few disinterested spectators remained. Together, the Red Cross workers and Miss O'Brien watched the last ambulance disappear down the road. Twilight peace descended over the village.

To complete the twenty-four hours of that memorable day, after a short rest, Miss O'Brien went to the County Hospital, a new institution in its infancy, with only one nurse. There she labored until early morning assisting at operations and with the application of splints. Of the fifty miners injured in the explosion only three or four recovered and they were handicapped in various ways for life. The local chapter immediately asked National Headquarters at Washington for help and advice. Speedily it came in form of a field representative, expert in handling disaster situations, and in the form of money, for the county being a poor one was unable to raise a sum sufficient to support the destitute. In addition National Headquarters assisted the local Red Cross chapter by partly financing an executive secretary—also a trained social worker—who, together with the county nurse, worked for several months on the rehabilitation of the families so suddenly made dependent.

**RED CROSS ROLL CALL**

Such was the typical experience of a Red Cross nurse. Those of us who cannot give active personal service to the Red Cross may show our interest during the Red Cross Roll Call, November 11 to 28, by enrolling as members and assisting in the campaign.

## IN THE HOUSE WITH A ROSE GARDEN

Just at the edge of town there is a grey, unpainted house in a tangled rose garden. Three people live there, an old man, dying with cancer of the face, a lovely old lady, and a man with a vacant look, carrying a bouquet of newspapers in his hand, his leg fastened to the bedstead with a chain. The chain rattles and drags on the floor as he crawls about. He has existed thus for thirty-two years.

Efforts were made years ago to have the chained man judged insane but all attempts had failed. His mother had at last come to feel that his life was quite hopeless and reading in the paper that a feebleminded boy had been judged and sent to the State School for Feebleminded people, she decided to call the public health nurse. Her poor son is now in the State Colony and the mother is able to go about her home without the sound of a chain moving on the floor in the next room.

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Eighteen students have been registered in the course for International Students, London, for the Session 1929–1930. Eleven of these are entered for the Public Health Nursing Course. They are: Elsa Aberg, Finland; Margareta Castren, Finland; Yvonne Dengel (Mme.), France; K. W. Ellis, Canada; Ellen F. Horn, South Africa; Elly Kurrik, Estonia; Maria I. Mandl, Austria; Joyce E. Nobes, Great Britain; Berta Heuer y Ritter, Mexico; Agnes Thorotzkai, Countess (Mme.), Hungary; Grace Trench, The Hon., Great Britain.

Seven students have entered the course for Administrators and Teachers in Schools of Public Health Nursing.

# Combining Against Tuberculosis

By Frances C. Clarke, A.B., R.N.
Providence, R. I.

DURING the past two and one-half years the Providence Tuberculosis League and the Providence District Nursing Association have been working out a relationship which, in our experience, is somewhat unique.

For twenty years the District Nursing Association had gone on with its tuberculosis work, unsatisfied with its results and with no intelligent criterion of how well it was reaching its goal. The Providence Tuberculosis League for some years had had an educational research and clinical program but also felt that it was not working with the desired effectiveness. The important and underlying principle behind all projects started was to have a better means for evaluating each day's and year's work, each nurse's work and to estimate how far the performance of this met the accepted standard.

Our first step was the organization of a Central Bureau of Registration to give improved tuberculosis service to the individual and the community through the correlation of all sources of information obtained in a uniform way. Due to the intelligent coöperation between the two agencies we have gone on to other undertakings, each considered as experimental in the beginning. Even now we are in a state of flux, testing each move by practicality and changing the emphasis of the work as the findings of our figures indicate. A glance at the situation of the two agencies in 1927 will show how the plan started.

### THE SITUATION IN THE BEGINNING

At this time the Tuberculosis League kept records of the medical examinations made by its physician at the League's office, the three city clinics and certain of the schools. In addition to the regular clinical work the League doctor did consultation work and, as adviser of the tuberculosis division of the District Nursing Association, worked for a closer relationship between the two agencies.

The District Nursing Association staffed the clinics and worked in coöperation with the Tuberculosis League. A medical summary of clinic findings was sent to the League and a copy sent on to the District Nursing Association. This copy to the District Nursing Association was the nurse's only report of a patient's visit to a clinic, and carried the only medical information they had of a patient.

As more patients were seen in the clinic more demands came to the District Nursing Association and to the League office for information from other interested agencies. The League's records gave no real indication of a patient's home conditions or the exact condition found on various nursing visits. For the medical information about a tuberculous patient or family to have full value it should be correlated with the social conditions of the home and the condition of the other members of the family.

For any interested agency to get this information, two telephone calls had to be made, one to the District Nursing Association and one to the League, for a fuller medical opinion than was reported to the District Nursing Association on the clinic journal. Each agency was in the awkward position of being in possession of half of the story with many details of it in the mind of the individual nurse who visited the family. This was noted on the record by the remark "condition fair," etc., and its elaborations.

### A POOLING OF RECORDS

The District Nursing Association had a foundation of twenty years work and was acceptable in the homes. They were willing to try various plans

to make their work more effective. Therefore the suggestion was made and tried that all nursing records should be brought to the League's office and be placed in the general family folder of the League. This would have been a fairly simple arrangement had the League and the nursing office been in the same building.

During the first period of trial it meant great difficulty for the nurses in planning their work and in carrying their families, until they became accustomed to working without their records. It meant various attempts on their part to find the best method of keeping the minimal necessary information in their office without a complete record file.

After various trials the records have been boiled down into this: In the League's office there is filed one family folder filled in from the nurse's old family card; an individual clinic card with a summary of the physical findings; an individual social history and individual nursing visit report card, a family summary card and, if a child is in the school study group, a special school-child report card. The nursing visit report card was devised to cover the essentials of the home call; the conditions found at the time of the visit were recorded on a daily report slip made out in duplicate and one sent to the League. This, in essentials, covered nothing that a good nurse did not cover under the former system, but brought out in detail the points of condition covered by the former all-enveloping "condition good." The social history contains in detail the patient's past and present history, a brief summary of the family's past history and a general summary of home conditions. The summary of home conditions was standardized as much as possible through consultation with authorities on rating of social conditions. The family and home conditions are rated in accordance with a system of grading worked out and understood by both organizations.

#### ROUTINE INFORMATION

The social history should be filled out before a patient's first visit to a clinic (if he is a patient from one of the nurse's families) so that the doctor may have the patient's pertinent history at hand at the time of the physical examination. (Insistence on this point has made a great difference in the ease of handling clinics and of getting patients examined.)

A nurse urges a patient to be examined, takes the history and sends the history in to the clinic to which the patient belongs. The history of a patient not known to the nurses, or without one for some reason, is taken at the clinic. The clinic journal, the connecting link of medical information between clinics, League and Nursing Association, is carefully kept up and gives the Nursing Association the latest medical report.

What was left to the tuberculosis nurse? The family card and individual date card (indicating frequency of visits) and the duplicate slip of the nurse's visit with full information of the symptoms and home conditions on the last visit (kept until the next visit) and the clinic journal. This seems a meager array after the full records previously handled by the nurse. However, after this length of time, we feel this record system is workable. It means frequent visits to the League office, especially for any new nurse, to familiarize herself with the whole family situation, and it has meant additional time for the nurse to spend not only on the clerical aspect of the records, but on the study of them. It probably makes for a more intelligent approach to the family by the nurse than in the past.*

* During the past two and a half years not only the actual number of examinations but the clerical work of the League has increased tremendously. At the present time there are on the tuberculosis service of the District Nursing Association ten field nurses, one assistant supervisor and one supervisor. They carried, July 1, 6,360 individuals in 2,418 families. The League has two doctors, a clerical force, statistician and a field worker.

Any question in the nurse's mind can immediately be talked over with the doctor, with all the information at hand. He, at intervals, goes to the nurses' staff meetings to discuss with the group any particular phase of the work. Closer contacts between the League doctors and the nurses have inevitably resulted and have made more evident the interdependence of each agency.

#### CLASSIFICATION OF PATIENTS

Perhaps the most important result of the centralization of the records is the fact that they are now available for study and for statistical work.

The first thing that seemed imperative after the records were all together in the League office was a re-rating of cases. Under the old system all cases were visited on a monthly basis with occasional more frequent visits as the need arose. A contact family was carried through one member, that one supposedly the most susceptible.

Under the new plan each nurse went over all her cases with the medical director, considering the social and physical conditions of the family as a whole, the physical condition of the individuals, the progress of disease and the closeness of the contact. As a result, the system of visiting was somewhat changed. Families were grouped into bi-weekly, bi-monthly, monthly, quarterly or semi-annual visits. *All contacts were taken on.* Old chronic and semi-uncoöperative patients were not allotted the same amount of visiting time that was given a bad contact family. Many uncoöperatives were dropped. This system resulted in an increase in the number of individuals carried, a re-adjustment in the number of visits made and a saving of approximately 30,000 nursing visits a year. In the first twenty-one months the individual records of the League increased from 3,000 to 12,000; the families, from 2,500 to 7,300. At a glance it would seem impossible that any group of ten nurses could carry intelligently 6,360 individuals and 2,418 families but we feel that, without the families lacking care or an overworked staff, it has been satisfactorily done. The corner stone of the whole system has been the classification of the patients.

#### NEW BASIS FOR RE-DISTRICTING

Another result of this first re-rating was the re-appropriation of the nurses on a ward basis so that each group of cases could be easily comparable to the ward's statistics.* In connection with this, a brief ward study was made emphasizing the racial make-up of the wards, types of industry, the general death rate from tuberculosis and the death rate according to age groups, nationalities, sex. This gave a brief introduction to the nurse new in the locality and supplemented the general information of the nurse already familiar with the district.

It is felt that once a year at least all families should be reviewed by the nurse and the medical director. The method used this year may or may not be permanent. It considered the different types of cases which had been into clinic and the ratio of reëxaminations on new cases. They were studied also to see in what nationality group they fell and if recent death studies by nationality indicated, they were examined. As a result the emphasis was shifted to certain age and sex groups and contact families and to more examinations among those in the large group with "deferred diagnosis." The findings indicated that the follow-up system was too broad and that, for the time being, intensive work on certain types of cases might be more valuable.

Patients felt to be definitely uncooperative (that is, who did not follow directions and did not go to private doctors or clinics), when not constantly exposing others, were put into inactive file. Certain of these were written a series of letters signed by the League's doctor. A difficulty in Rhode Island has been that there is

* The reader is reminded that the tuberculosis nursing service in the Providence District Nursing Association is carried by a specialized staff.

little or no compulsory reporting of cases and, hence, no regular follow-up system by the state authorities to whom cases are reported for enforcement. Certain families, where, over a period of years, little progress has been made and where there was no immediate source of infection, were also put in the inactive file. Some of these would, probably, after a time, ask the nurse to resume calling.

Quite a large group, most of them reactor school children, were transferred from the District Nursing Association's active visiting list to the League's letter-group.

#### A GRAPHIC PICTURE OF THE SITUATION

Now information has been gathered on each nurse's case-load, type of case, best method of follow-up from the content of each city ward as regards actual and potential tuberculosis cases. This is presented graphically by a large chart under the same study headings that the daily clinic information is gathered. At any time the clinic cases may be compared in any number of ways with the number of potential cases in any ward case-load. From the nurse's point of view the result of this last re-rating is that the emphasis is to be on fewer cases with more intensive work on them. They visit active tuberculosis cases, contact families and returned sanatorium cases. In all, especial emphasis for reëxamination is put on the important adolescent years for males and the years of early maturity for females.

To keep up the right proportion of new cases and to encourage case-finding the idea was suggested that staff nurses other than those in the tuberculosis service, should send in, on a competitive basis, patients who, in the course of their daily rounds, seemed suspicious.

#### RESULTS THUS FAR

The League has gained from this intensive ward and nursing analysis in several ways. First, it has developed more fully the need of a complete letter follow-up system with special appointment times at clinic. It will be some time before the system is well worked out. Second, the League has gathered a great deal of valuable statistical material from which many studies of nationality, age, industry, etc., connected with tuberculosis may be carried out.

We now know the present situation. This, with the standard set by the American Public Health Association and our daily performance, acts as a constant check on our work. The nurse knows just where her time and work should be expended. We still feel we are in the experimental stage, but it has been proved two organizations, one without a full set of records in its office, can carry out a program, test it by practical results, change it and evaluate it again.

## HAVE YOU A MENTAL HYGIENE PROGRAM?

The Mental Hygiene Section of The American Nurses' Association is endeavoring to be of service in advancing the preparation of the student nurse in the field of mental hygiene. An effort is being made to find out how much mental hygiene education is being carried in (a) schools educating student nurses; (b) organizations providing a program of staff education. It is probable that a great deal more is being done in this field than we are aware of. Will any nursing school or nursing organization, including public health nursing agencies, assist in this effort to secure more information by sending a statement in a few words telling exactly what is being done in this field of nursing education?

Replies should be sent to the Secretary of this Section—Miss Anna K. McGibbon, Butler Hospital, Providence, Rhode Island.

# How the Negro Health Center in Tulsa Came to Be Built

By Sadie Stewart Hobday, R.N.

ON the first day of July, 1923, I arrived in Tulsa, a city built on the hills, with wide streets lined with shady trees. No one had described Tulsa to me and I was overwhelmed with the beauty that met me on every side.

Naturally I was eager to see the moving spirits of the Tulsa County Public Health Association, the organization of which I had become a part, and so wasted no time in seeking the organization headquarters.

There I met two women, keen, wise, worthy; but the depth of their wisdom I only learned later under their kind guidance. The information they gave me that troubled me most was that there were 15,000 negroes in Tulsa and only one public health nurse. This seemed seven and a half times what should be the work of one nurse. The first step was to take an inventory of what Tulsa offered to fill the gap between me and the missing six and a half nurses.

These are some of the things I found on the credit side: eighteen negro ministers of the gospel, more than half representing such colleges as Harvard University, Fisk, Union and Howard, twenty physicians, representing some of the best institutions in the country, high schools, junior high schools and graded schools supervised by Dr. P. P. Claxton, who at one time was U. S. Commissioner of Education. Here, then, was a sound working basis.

### BEGINNING TO WORK

The clinic, which was to be my work shop, was in a massive brick building. Winding our way up the narrow dark stairway we came to the second floor and entered the door leading to the clinic. A neat little attractive waiting room and an immaculate examining room composed the set-up. This was not what these pioneers wanted nor what they were willing to keep. Those two little rooms had been a connecting link between the physical needs of the people and the hospital. These two rooms further symbolized greater service and better citizenship.

My first visit in the district increased my anxiety for a real health center. As I said, Tulsa is a city of hills, but what about the valleys that must be in order to have hills? It was in the valleys that I found most of my families living. This settlement was so new that it was known as the "Addition." These were the people who were unable to carry on normally after the Tulsa racial disaster and hence were forced out here. Here and there were comfortable homes, but mostly makeshifts. Some were only basements where people housed waiting for a better day when the buildings could be completed.

The most pleasing aspect of my first visits was the intelligent understanding of health that existed among the families. Diseased tonsils had been removed, vaccinations had been done, large numbers had been immunized against diphtheria and the untrained midwife was being thought of as unsafe for mother and child. All of this showed that a splendid piece of work had already been carried on among these people. It also showed a spirit of trust in this organization, because of the efforts of two splendid women, of whom I have already spoken.

### PROGRAM OF WORK

From the beginning we held three clinics a week regularly—child welfare, prenatal and tuberculosis. Three of the negro doctors gave their time for these clinics. All of the doctors, both white and colored, were most generous in giving time and advice and

would even make home visits. Some of the most outstanding specialists, whose clientele was exclusively among the rich, would see these humble patients, free of charge, in their beautiful offices and render the same type of service as they rendered to their private patients. This gave us an unusual opportunity in our health work.

Once a year we held a Health Week. We used one of the large churches, curtained off into clinic rooms. The community was invited to have a

*The Health Center*

yearly physical. Here the specialists would come to us. The response from the people was always so great that an extension of time was necessary. All of the colored doctors took part either as assistants or as observers.

### "RESERVED FOR HEALTH CENTER"

While the regular health program was going on every effort was being made to get a permanent clinic. I found my way to the Ministerial Alliance and to the Medical Associations, and Sunday after Sunday I spoke in the different churches. Responses from these contacts were constantly being reported to the Board of Directors.

In Tulsa we had negro architects, contractors, electricians, plumbers and all other types of workmen, who would be needed to carry out the entire building of a health center. This I had been emphasizing in all my contacts in a general way. I felt keenly that the people had seen the vision, that if they combined their efforts they could make real this vision and be an example of unity through organization.

At last we reached a point when we went to the city authorities and presented our plans. I shall never forget the sincere look of sympathy on the mayor's face, and afterward, the glad news came that the very spot for which our hearts longed had been given to us for ninety-nine years, provided the negroes themselves built this clinic, as had been outlined. The people had heard of "health center" for months and suddenly they went by a vacant lot and saw a large sign attractively designed in large letters saying "Reserved for Health Center." "Reserved for Health Center" became my text. Everywhere I went I preached it.

### BUILDING THE CENTER

One of our board members was an architect. We outlined to him the building that was in our minds and he drew the plans for us. Money, brick, lumber and laborers came fast as donations. More than three-fourths of the labor was donated. Not all of the workmen could afford to do it from an economic standpoint, but they wanted to give and did give. The one-fourth that were paid gave a part and were paid a part. All the churches helped in the effort. The National Tuberculosis and Health Association donated a special part of all the money derived from the sale of Christmas seals sold among the negroes.

The building was soon being erected. It was a stirring sight to see the men, all colored, laboring not for themselves, but for the city of Tulsa, for things pertaining to health as a community interest.

When the building reached the point for laying the corner stone, we had a most impressive service. More than two hundred dollars was donated that day towards the building. This was a substantial expression of the people's appreciation.

At last the little brick clinic was all completed. A picture of this is indelibly stamped on my mind. I do not see just the beautiful waiting room,

the demonstration room, three dressing booths, fully equipped examining room, and the quiet private office for the nurse, but I see a complete piece of work built on the confidence of

*For Better Babies*

negroes—each in the other, on trust, and loyalty to those who expected the best for them. The first clinic in the new building was held June, 1925. How proud the people were of their new quarters!

A great deal of the work is done through group teaching in the Center. Special lectures are given by the doctors in the churches. The nurse lectures in church when necessary in order that all churches may be covered. The teachers coöperate in giving health plays and making health posters. Many of these plays are given in the evening, so that the parents may see them.

One year after I went to Tulsa the Board of Education became interested in putting on a colored school nurse. The next year came a school doctor. So we increased our number for that fifteen thousand!

Word has come to me since I started this article from the nurse who is now supervising the Center that Tulsa has a colored health officer, not the old fashioned health officer who held the rod of power, but a man well versed in public health. Along with this message came the news that a dentist has been added to this chain of workers. As might be expected the growth of the work is very gratifying to me.

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*Colored Nurses on the Staff, Public Health Nursing Council, Nashville, Tenn.*

Two of these nurses were granted Rosenwald scholarships and have completed work at Teachers College and Henry Street Visiting Nurse Service.

The service of the colored staff is generalized, covering all types of work including child welfare, prenatal and tuberculosis clinics. In 1928, 3,602 patients were cared for, and 29,244 visits made. The nurses have an annual exhibit at the Tennessee State Fair.

# Convention Report, National Association of Colored Graduate Nurses

The 22nd Annual Convention of the National Association of Colored Graduate Nurses met in New York City August 19–23, with headquarters at the Young Women's Christian Association. The president, Mrs. Carrie E. Bullock, presided at the opening meeting and welcomed the delegates, of whom there were more than 200 present. On Tuesday, August 20, Miss Belle Davis, Executive Secretary of the National Health Circle, reported on the need for scholarship funds, and two scholarship nurses told of their work.

Miss Davis stated that The National Health Circle has given ten scholarships to public health nurses in nine years. She spoke of the low salaries that colored nurses are receiving and of the discrimination against colored nurses in relation to salaries which exists in the South. She stated there is opportunity for the well-prepared colored nurse and cited two requests that have come to her within the last year for information as to public health nurses with degrees to head courses at universities. She mentioned the difficulty of training nurses in the North for work in the South because after a year spent in New York in contact with Harlem the nurses are loath to make the necessary sacrifice entailed by accepting a position in the South. She announced that courses will be started at Howard and Fisk and possibly in a third university.

On Wednesday morning brief reports of local associations were presented and gifts to the national organization of subscriptions for relief fund were reported by local delegates. The subject of the morning meeting was How Welfare Agencies Are Working to Reduce the Negro Death Rate—Genevieve H. McKinney presided.

Miss Jennie Tresevant, Welfare Nurse, Adam's Run, Columbia, S. C., gave a vivid account of the organization of pioneer work, describing the backward condition of the people during the first part of the work, emphasizing conditions in connection with midwives. The Harmon Fund, at her suggestion, finally supplied the money for a clinic for both white and colored people in the county of Charleston, with support for a number of years. Miss Tresevant then told of the marked changes which have occurred since she started the work. She concluded with a plea for nurses "not to be ashamed of working in rural communities," as the only way to develop them is by the work of good nurses—and the rewards in the way of results repay any efforts, no matter how difficult. To brighten her report, she told this story:

She had a checking up on dental hygiene, one morning. When she asked the children how many washed their teeth every day Marietta's hand failed to go up. "Why not, Marietta?" asked the nurse. "Mama says I'm not old enough to use a tooth brush—I'm only ten years old!"

Dr. Alonzo Smith of New York City gave an admirable brief talk commenting on Miss Tresevant's work. He congratulated her on her courage and endurance but made the pertinent query "Where were the doctors?" He specially urged the need for good basic education so colored nurses might be ready for all responsibilities in situations such as she had described. He made the point that nurses must remember that their own education should continue by means of post-graduate courses or whatever means possible in order to keep up with new ideas and practice. He stressed the point that negroes should appeal more to their own race, especially the more fortunate members, for support for public health work to make conditions more tolerable for the unfortunates.

Miss Alta Dines also spoke at this meeting and Miss Lillian D. Wald was guest of honor at the luncheon meeting.

The Thursday meetings were devoted to mental hygiene, and private duty nursing, and Friday to nursing education. Entertainments were held during the week closing with a formal reception at the Renaissance Ballroom.

Throughout the meetings there was a spirit of quiet serenity and a seriousness of purpose which large gatherings often lack. The association is to be warmly congratulated upon a successful and profitable convention.

# Public Health Nurses in the Civil Service

*With Special Reference to the Merit System as It Affects Them in the Federal Service*

By Rachel Walp, R.N.

*Foreword:* The public health nurse in relation to civil service is worthy of an extended study of many months, but a practical insight into the problem may nevertheless be obtained in a comparatively brief study of the services in the federal government and in the governments of New York State and New York City. A previous article on Civil Service appeared in The Public Health Nurse, July, 1929.

TO the average person a "civil service employee" means one holding an official position secured as the result of an examination previously held to test the comparative fitness of the several candidates. Properly speaking, however, "civil service" in the government is any service of a nation, state, municipality, or other political subdivision of a state excepting military or naval. Even the hordes of men hastily recruited to work for a day or two removing snow from the city streets are as strictly civil service employees as are the municipal engineers who were required to meet rigid educational tests in order to qualify for appointment. The difference is that the engineer was appointed in accordance with a "merit system," the operation of which is entrusted to a special commission designated a "civil service commission," while the snow cleaners represented a group of men picked up in a hurry from tramp lodging houses and other places and hastily thrown upon an emergency job. Even for such supposedly unskilled work as snow removing it is admitted that the many physically weak men or unreliable workers add to the cost of the job, despite the driving and supervision of the snow cleaning bosses who are generally regular city employees.

### GENERAL HISTORY

In the past this and foreign governments tended to offer positions only to their political henchmen or parasites or to court favorites. In the last fifty years this and other governments have done much to abolish this abuse of political power.

In 1883 Congress passed the basic law providing "open competitive examinations for testing the fitness of applicants for public service now classified or to be classified hereunder." It specified that "examinations shall be practical in their character" and that positions should be "filled by selections according to grades from among those graded highest." It placed the general employment administration in the hands of a commission—the United States Civil Service Commission. "Classified" positions now number over 400,000 in the federal service. The spoilsman in politics still finds some "practical" openings outside the merit system, but each year shows improvement along these lines.

At present Civil Service Commissions, or similar groups to administer the merit system in the selection, appointment, promotion and retention of Civil Service employees exist in the federal government and in the following named states, Massachusetts, New York, New Jersey, Maryland, Ohio, Wisconsin, Illinois, Kansas, Colorado and California, and in about 300 cities.

### DEVELOPMENT OF QUALITY OF EXAMINATIONS

As a nonpartisan or nonpolitical employment agency it is a province of Civil Service Commissions to recruit a force from which services may draw employees. To do this successfully the commission must be in a position to develop such sane and just provisions concerning salary, promotion, transfer, leave of absence, retirement and pension, etc., as will be fair to the government and reasonably attractive to a

high grade of candidates. Each of these several subjects has been in itself a topic of investigation and research by official and unofficial organizations in this and other countries.

The fitness of the nurse for a position in the Civil Service is tested in the same way as is the fitness of any other applicant in the Civil Service, namely, by means of an examination. The Civil Service Commission has adopted two types of examination designated: (a) assembled and (b) nonassembled.

In the first type of examination the usual procedure is to assemble the applicants in various parts of the United States and subject them to written or oral tests. In nonassembled examinations, on the other hand, the applicants are not required to meet for a written test but instead submit to the Civil Service Commission statements covering education, training and experience and in some cases must file copies of their publications. All their statements concerning training and experience of course are subject to verification.

None of the nurse examinations announced by the Federal Civil Service Commission are assembled examinations excepting that for trained nurse and trained nurse psychiatric for the Panama Canal Zone. In the assembled examination the written test, which covers questions in anatomy, hygiene, and nursing has a weight of 80 per cent in the total rating, while education, training, and experience has a weight of 20 per cent.

The examination held prior to appointment is the preliminary test of fitness for the position. The Civil Service Act and rules require appointment for a probationary period of six months during which the employee's practical fitness for the job is tested. Within this period any appointing officer who deems an employee unfit in any way may immediately discharge such employee. Assuming that the examinations or tests have been developed to a high degree of practicalness, it still may sometimes happen that persons appointed as the result of high ratings may be inadequate or unsuited to the particular position to which assigned. The elimination of such a person during his or her probationary period of appointment offers practically no difficulty.

If, however, an appointing officer does not take advantage of his right to remove an incompetent employee during this probationary period or if the employee deteriorates after expiration of this probationary period the appointing officer still has the right and the obligation to submit in writing to the Civil Service Commission a statement of the nature of the inefficiency of the employee or of his or her unsuitability for the position held. The employee is not given a personal hearing but the Civil Service Commission takes action on all legitimate charges. The law gives the administrative officer power to remove any employee who lacks the ability to fill his place or who lacks the will to render the standard of service demanded.

In some cases the stated requirements are subject to deviations along clearly defined principles. The Commission, however, is generally adverse to suspending its usual requirements owing to dangers of abuse. It scrutinizes carefully the claims of appointing officers who seek temporary employees elsewhere than on existing eligible lists and hesitates to make such temporary or probationary appointments if it is feasible to hold within a reasonable time a competitive examination. Moreover a possibility exists that a bureau head may favor certain applicants and seek to have them given temporary appointments in order to give such persons a period of experience which will enable them to qualify.

### NURSES IN MILITARY AND NAVAL SERVICES

In the Federal government public health nurses are employed in the Military and Naval services* of the United States and assigned to duty throughout various hospitals in Continental United States or Insular pos-

* Appendix No. 1 comprises circulars issued by the War and Navy Departments giving further details on the Army and Navy Nurse Corps.

sessions and on board ships. They are appointed through the Surgeons General of the Army and Navy respectively and are completely outside of the scope or control of the Civil Service Commission.

In the Navy, approximately 450 nurses are on duty at the naval hospitals and about 50 on the hospital ships, in the dispensaries, at the Hospital Corps Training Schools and in the office of the Superintendent of Nurses at the Bureau of Medicine and Surgery, Navy Department. The nurses do no occupational therapy work, home visiting or follow-up tuberculosis. In the Virgin Islands, Guam and Samoa, native nurses under the supervision of the navy nurses, do public health and welfare work but the navy nurses, themselves, do very little of it.

#### CIVIL SERVICE NURSES

The Bureau of Education under the Department of the Interior appoints nurses for its Alaska service among Indians. Owing to the delays and difficulties involved in canvassing the list of persons on the regular Civil Service register to find those who will accept Alaska service and also because of peculiar or unusual requirements that must obviously be met in this remote partially Arctic territory, special latitude in making appointments would not necessarily lead to political abuses and might in fact be the only practicable means to secure nurse recruits.

Freedman's Hospital, operated by the Interior Department for the care of Negroes is faced with the fact that colored nurses would be more prone than white to accept duty here. The hospital school, therefore, trains its own nurses and makes appointments from its graduates. All graduate nurses are appointed through the Civil Service Commission. Student nurses are appointed through the local board of the hospital staff, appointed by the Civil Service Commission.

The Public Health Service, the Indian Bureau, the Veterans' Bureau, the Children's Bureau and the Government Hospital for the Insane employ the majority of nurses in the Federal Government who are not in the military and naval branches of the service. All of their appointments are under the control of the Federal Civil Service Commission.

Still other positions in the Federal service that have come under the Commission have as partial requirements for eligibility certain training that, it is believed, some nurses might well have had and could therefore offer for consideration or credits, as dietitian, occupational therapy aide, physiotherapy assistant.

#### SUMMARY OF CIVIL SERVICE NURSE POSITIONS

A letter dated March 31, 1928, received from Miss Jessie Dell, U. S. Civil Service Commissioner, gives information concerning the distribution of these groups in the civil branches of the Government:

"Public health nurses, medical social workers and psychiatric social workers are under the jurisdiction of the various Veterans' Bureau hospitals, hospitals of the Public Health Service of the Treasury Department, and hospitals of the Indian Service under the Interior Department. Dietitians come under the jurisdiction of the Bureau of Home Economics, Department of Agriculture. The Veterans' Bureau employs a number of dietitians, as does also the Public Health Service."

#### TYPE OF EXAMINATION

For Graduate Nurse competitors were not required to assemble for examination at any place, but were rated on (a) education or training, and (b) experience. The relative weight of these two requirements is not stated in the announcement.

For Consulting Public Health Nurse and Expert in Maternal and Infant Hygiene, the examination is also non-assembled, but a publication or thesis must be filed with the application. For Consulting Public Nurse, education and training has a weight of 25; experience a weight of 50; and the publication or thesis a weight of 25. In the other positions education, training

and experience combined have a weight of 80 and the thesis 20.

The Panama Canal Service, unlike other Federal services, requires candidates to "assemble" at indicated points throughout the United States and territories and the Canal Zone, according to residence. Competitors are rated in "practice questions in anatomy, hygiene and nursing," which has a weight of 80, and also on education training and experience which has a weight of 20.

#### GENERAL QUALIFICATIONS

*Citizenship:* Positions in the Federal Civil Service with but few exceptions, are restricted to citizens of the United States. The only exception noted in nursing positions is in the Panama Canal Service.

*Sex:* Both men and women may enter examinations for nurse positions available through Civil Service but the appointive officers have the legal right to specify the sex required in requesting personnel. The only instance where a preference was indicated for men in nursing positions was in the Panama Canal Service, which makes special effort to secure male nurses.

*Age:* The age specifications set forth for the several examinations are as follows:

Graduate nurse, graduate nurse (visiting duty) and graduate nurse (junior grade): Not less than 20 nor more than 50 years on date of making oath.

Consulting Public Health Nurse: Applicants must not have reached their 45th birthday on date of examination.

Expert in Maternal and Infant Care: Applicants must not have reached their 55th birthday on date of examination.

Trained Nurse: Trained nurse (psychiatric). Female applicants not less than 20 nor more than 35 years of age on such date.

*Academic Standards:* For the Graduate Nurse positions applications are not accepted from anyone who has not had at least two years of a standard high school course.

*Professional requirements:* The Graduate Nurse examination seems to be the basic one for securing most of the nursing personnel throughout the Federal service. The professional requirements as set forth may be said to meet reasonably high requirements.

*Registration:* The post of Graduate Nurse demands "evidence of state registration." Consulting Public Health Nurse applicants "from states having nurse-practice laws must submit evidence of registration with their applications," but for Expert in Maternal and Infant Care, and Trained Nurse for the Panama Canal registration is not required.

*Years of training:* Graduation from a recognized school of nursing requiring a residence of at least two years in a hospital of specified bed capacity is called for in all four of the positions noted.

Panama Canal Service examinations are the only ones open to undergraduate nurses, and then only if they can furnish evidences that they will graduate within six months of the date of examination and that they will have had at least three years' experience in a modern well-equipped hospital by that time.

*Specialized nurse training or experience:* Certain extra training or special and post-graduate work improves the score in rating applicants. For Consulting Public Health Nurse, at least eight months' study at a school of recognized standing giving post-graduate work in public health or visiting nursing and at least two years of infant and maternal nursing or public health nursing which has included this. Five years as an executive in such a nursing organization will be accepted in place of the post-graduate work.

#### SALARIES

The Graduate Nurse register is a general one for the Federal Departmental Service as a whole. The principal services which select from this list are the Veterans' Bureau, Public Health Service, and Indian Service but other branches of the government may draw from this list. Basic salaries ranging from $1,440 to $3,000 in certain branches of the service are subject to deductions for quarters, laundry,

subsistence, etc. Generally, but not always, appointment is made at the minimum rate and future promotions take into consideration length of service among competent employees.

#### CIVIL SERVICE ADVANTAGES

An evaluation of civil service employment to nurses must rest largely upon one's opinion of such conditions as the following:

Reasonable assurance of security in office, if well qualified; allowance of thirty working days for annual vacation with an additional thirty days' leave in case of illness; reasonably favorable and regular hours excepting in emergencies; opportunity for travel in some services; opportunity for excellent training on the job in most cases; reasonable assurance of competence and more than average ability of nursing, medical, and lay colleagues; possibly as good chance of promotion within the government service as elsewhere. On the other hand, the top salaries of the Federal Service are not as high as those paid by certain municipalities and states and by certain nonofficial nursing groups operating on a national or local basis.

Another marked advantage of Civil Service employment in the Federal government is the provision for retirement and pension. Classified employees who have reached the retirement age and have served fifteen years are entitled to retire with an annuity. A deduction of 3½ per cent is made from the monthly salary to provide for this annuity. The money paid into the annuity fund will be returned to persons leaving the service before retirement, plus 4 per cent interest, compounded annually.

Individual applicants sometimes question the quality of examinations held in various cities and states, that is, whether or not such examinations are true tests of the applicant's fitness for the position and also whether or not the persons who rate the papers are always fair and capable. It can only be said that the quality and efficiency of the various state and municipal Civil Service Commissions varies considerably. The Civil Service Reform Commission and other responsible bodies, however, concede that the United States Civil Service Commission today is unquestionably nonpolitical and honest and, furthermore, that it has developed a high standard of efficiency.

To an administrator of a bureau or office it is a great advantage to have recourse to a scientific personnel board, genuinely concerned with the constant improvement of the Federal service. Moreover, once an eligible list is established the Commissioner tends to all the details of procuring personnel. The six months' probationary period permits the administrator to drop incompetent employees without an undue amount of red tape. Should unfitness develop after the six months' probationary period the administrator may bring charges, a copy of which is made available to the employee concerned, and the incompetent worker may be dismissed. The fact that in common practice administrators hesitate to bring charges can hardly be held as a weakness inherent in Civil Service procedures.

## THE 1930 BIENNIAL CONVENTION

June 9–14, 1930, the Biennial Convention of the three national nursing organizations will be held in Milwaukee, Wisconsin. Early as it seems to think about it, committees are already at work in Milwaukee and at headquarters, and our readers are urged to watch for important announcements in the coming numbers of the magazine. The Hotel Schroeder has been selected as headquarters for all three national nursing organizations.

# Reminders to School Nurses

## *Conserving Sight and Vision Testing*

PART II *

By Mildred J. Smith, R.N.
National Society for Prevention of Blindness

THE most perfect conditions for eye work even though present from earliest infancy cannot assure perfect eyesight. Inherited tendencies, accident and disease may individually or together influence vision ability.

In a sight conservation program, the second responsibility of those concerned with the welfare of children lies in the early discovery of suspected eye strain or lessened acuity. The importance of early discovery is not toward development of physical health alone but toward mental health as well. Observation of eye condition and visual ability should be made while the child is at work or play as well as during the time of inspection.

The opening words of the volume dealing with eyes of the National Health Series are "Sight is essentially a process of the mind." [4] With this conception in our own minds, vision testing may become quite as interesting as it perhaps has been considered arduous in the past.

### GOOD EQUIPMENT ESSENTIAL

Knowledge of scientific laws governing sight shows us the necessity of a properly arranged set-up if accurate acuity tests are to be made. The better we know the "why" of good equipment, the better able we will be to select that which is good without incurring undue expense. Our information should be sufficient to enable us to adjust to variable situations; it also should be such as to enable us to give practical, reliable help to others whose working conditions may differ widely from ours.

The Line of Letters and the Symbol E charts made according to the Snellen scale are generally agreed upon as the most satisfactory in public health practice. The chart surface should be white and with a flat finish; it should be kept clean. The letters or symbols should be printed accurately to scale (according to feet only, not meters), sharply defined and dense black. The chart should be so placed that the line marked to be seen at 20 feet is approximately at the level of the child's eyes. The younger children, who are happier and more relaxed if able to move about, had better stand for the test. In the upper grades and high school, pupils may be less self-conscious if seated. There will be some little variation in height of chart for these several ages, so adjustment of chart should be easily possible.

In fairness to the child, in fairness to our own program and in the interest of statistics, data collected at one time should be as comparable to that collected at all other times as is humanly possible. Variation in quantity and quality of light means variation in acuity. Our first thought, then, should be directed toward lighting of the chart.

### LIGHTING THE CHART

Artificial illumination is more satisfactory than natural, because of its constancy. Ten foot-candles is the minimum of light to be used in testing. Any amount above this will give satisfactory results; below this amount, will not. The safer rule is to have more than sufficient rather than just sufficient light.

* The first part of Miss Smith's article appeared in our September number.

[4] "What Everyone Should Know About Eyes," F. Park Lewis, M.D. National Health Series, published by Funk & Wagnalls Company of New York. Price, 35¢.

The light in the room as a whole should approximate that which falls on the chart; in other words, a darkened booth is not advisable for testing as done in the school. If uncolored and frosted on inner surface, 40 watt bulbs will give good light on a chart; if of daylight type (blue and frosted on inner surface) the 60 watt bulbs are satisfactory. The shade should be of such shape and finish on the inner surface that light is evenly and well reflected.

Artificial light is not always available, so the best possible use must be made of the natural. It is true, of course, that nothing is better than good daylight. Where natural sources are being depended upon, some ingenuity may have to be exercised in order to secure the best light possible. In this case, a movable chart rack may be of distinct value. It has been necessary in some localities for the vision testing to be done out-of-doors. Whether the light be artificial or natural, the chart should be so placed that the child is not facing the source of light nor receiving any glare either from that source or as reflected from the chart itself.

Not only light but distance is important in securing accurate chart readings. The test should be made from a distance of 20 feet. Therefore the room should be such as to give a little more than that distance between the chart and child.

In meeting these standards, which seem acceptable to authorities, the nurse has at least provided the mechanical means for making a good vision test. From here on, her thought must largely be within the field of psychology.

#### THE PSYCHOLOGY OF SEEING

In order that we see accurately, the mind must be free to receive and interpret impressions brought through the eye by light. Proof of this is seen every day. Emotion may blind us to the most apparent things; embarrassment keeps us from seeing even that which is conspicuous. In order that we secure an idea of how much the child is really able to see, we must put that child into an attitude of mind in which he not only wishes to see but also wishes us to know what he sees. In this ability lies the art as well as much of the interest of vision testing. Trying to follow a mere routine of procedure cannot be successful in a test so dependent upon mental reactions, as is the vision test. Fortunately children are similar enough in their responses so that a great many will adjust to a like procedure. In the kindergarten and early grades, in any special classes that there may be, and in those cases in which an individual child seems somewhat of a misfit in the general scheme of things, added time, patience and skill will necessarily be used.

For the little child, the Snellen E chart is generally considered the best. Other charts and guides have been used and, in some instances, quite satisfactorily. The disadvantage of using a different system for the little people from that used for the older ones is not only one of possible inaccuracy, but as a matter of sequence in reports it is well to have the same system of recording used from the first test right through all subsequent ones. The Snellen E may be used for any age, child or adult. Although with a little child we sometimes have to work with large letters before he is ready to be interested in the smaller ones, this practice is not usually necessary for the older child. It is well to have the full Snellen chart from the 200 foot size letters down to the smallest ones in order that definite findings may be put on record. For the majority of children the larger letters, probably through the 50 foot line, may be covered in order that time be saved.

#### TAKE TIME!

Time is an important factor. Time, however, is not more important than the health and well-being of the child and should not be saved at the expense of honesty in work. The best ways to save time are by *providing as nearly*

*perfect physical arrangements as may be and by adjusting ourselves to the mood of the child* so that we may readily secure from him a true idea of his ability to see.

Because it is still in its process of development, the eye of the little child will naturally fatigue more quickly than that of the older child or adult. One child will differ from another in the amount of work possible before fatigue sets in. Testing first with one eye, then the other on each line with young children is done to avoid fatigue. Reading down with each eye through all lines exposed can probably be begun in the intermediate grades. Physiological not chronological age alone will be among the determining factors. A small card or folded paper rather than the hand should be used for covering the eye.

#### NORMAL READING

With a correctly made chart, well placed and illuminated, we can expect the normal eye to give a reading of 20/20. However, for the child of kindergarten age, early grades, a reading of 20/30 seems acceptable as normal to the majority of ophthalmologists. Unless the child is unable to see the 200 foot size letter at 20 feet, he should not be moved forward. The kindergarten child may have to work up from the 5, the 10, the 15 feet line before ready to see at 20 feet away, but that is a matter of adjustment to new distances. The whole matter of bases upon which to report children for examination following inspection should be taken up with one's local board and medical authorities.

It is well to have any child read the 20 foot line near the chart and again at the 20 foot distance. This is particularly important with the younger children in whom a high degree of accommodation is possible. The child who is quick and definite at the chart, but who at the 20 foot distance is much slower and less definite, should be referred for examination. The child who makes more than two errors in the line of letters would be considered as unable to read that line. In using the Symbol E, a vertical and a horizontal should be recognized properly; seeing correctly two out of three figures as presented would be considered as showing ability to read the line. In indicating letters or symbols, care should be exercised to give variety. A covering card, cut to expose just one letter at a time, is of distinct advantage over the pointer, since the latter is not only confusing but allows the child to use his sense of location and, therefore, his memory. The sense of location is developed very early. For the smaller children the cover card is almost indispensable in its aid to concentration.

Failure to read the chart through the expected line does not necessarily indicate myopia (nearsightedness). There are other causes that may be responsible for errors made. To the one making the inspection, however, the fact that the child fails to see normally is all with which she need be concerned. At the same time the acuity test is being made, there should be observation of the position in which the child holds his head. If, in order to see, he tilts his head in an abnormal position, it may be inferred that there is possible trouble in the eye that makes this posture necessary for clear vision. Therefore, the child should be routed for medical examination. Posture, of course, is often more easily noted during the regular schoolroom work than at the time of inspection.

#### APPEARANCE OF THE EYE

Important as is the acuity test, it does not give the whole story. The appearance of the eye is significant. Bring to mind the picture of a normal eye—unscarred, the whites of a bluish-white, pupils evenly dilated and neither of a pinpoint nor unnaturally large size, both eyes working in perfect conjunction and the whole effect one of clearness and alertness. The eye which deviates from these expectations is not normal in appearance and medical examination is indicated.

Any evidence of squint (crossed

eyes), periodic or constant, should receive medical attention as soon as noticed; school age is considered late for the best correction. A simple test may be used to detect muscle imbalance not otherwise noticed perhaps. Hold the head of a large pin—or anything the size of a small pea—about 12 inches from the child's eyes and in line with his nose. Cover one eye at a time. Have the child watch the pin. Observe the covered eye as it is uncovered; with good muscle balance, it will be fixed on the pin just as is the other eye. If the eye as uncovered has to move in order to be in adjustment with the other eye, poor muscle balance may be suspected.

To observe pupillary reaction to light, place child facing bright light, cover both eyes for a few moments and watch change in size of the pupils. The change should be simultaneous and fairly rapid.

The lids also may be indicative of possible eye trouble. The lining or conjunctiva should be of a healthy pink and smooth. No crusts, no "styes," no inflammation or swelling should be evidenced. Any one of these named conditions or over-redness or roughness of the lining of the lid are symptoms to be studied just as is the failure to read the chart. Any one or several of these symptoms may be due to eyestrain. Eyestrain may be quite as harmful in effect as is the inability to see.

### BEHAVIOR

Last but not least, behavior is to be considered. Ophthalmologists find some of these cases most in need of correction are those which have been referred to them because of behavior symptoms. The relation of the eye to the nervous system makes the effect of eyestrain upon behavior a perfectly reasonable thing and an influence to be reckoned with. Oculists urge that more attention be given this phase in our prevention program. The disinterested, the supposedly dull, the irritable, the oversensitive child may be one in whom there is a serious eye fault.

### OTHER INFLUENCES

Trouble suspected because of some indication in any one or several parts of the inspection made of the eye may or may not originate in the eye itself. Conditions in other parts of the body have their influence upon the eye—malnutrition, infection and so forth. It would seem wise, therefore, to route the child to the family doctor in order that a general examination may first be given, perhaps disclosing conditions that are affecting other parts of the body as well as the eye. It is also within the doctor's province definitely to direct the child for consultant service.

In eye as in every phase of health work, we should constantly keep in mind and bring to the mind of others the inter-relationship of organs and functions. Since the eye is not a thing unto itself, unsatisfactory reading of the chart, abnormal appearance of the eye or lids, symptoms of pain and discomfort do not necessarily indicate faulty construction of the eye nor the need of wearing glasses. It is a common fault that eye troubles and glasses are linked as inseparable error and correction. Glasses probably are the most usual means of correction in eye fault; they are not the only means, however, and should not be so considered.

### TEST BEFORE SCHOOL ENTRANCE

As more persons are trained to make acuity tests and observations of conditions that may relate to the eye, it will become increasingly possible for every child to have a test and inspection at the first of each school year. Although the records are not yet tabulated following the study of a thousand kindergarten children in Brooklyn and Manhattan, it is known that there are a sufficient number of defects even among these little people to make testing and inspection essential before school entrance. Effort should be directed toward meeting this need. School vision testing should be begun in the early part of the child's first year. Other than the routine annual tests, special emphasis must always be

placed upon the need for eye inspection of those children who in any way are, or are becoming, misfits in the social and educational scheme of things or whose parents are known to have ocular defects.

There is often disappointment in the percentage of medical examinations and of corrections secured following vision tests. Better understanding of the importance of the relationship to the whole health and better methods of inspection will serve to promote greater understanding and appreciation of this work. In the meantime, it is well not to be discouraged by the lack of definite results. If a child is suspected of a handicap which may influence him in his school work and in his behavior, the very fact that there is a suspicion of such will, in a majority of cases, mean a wiser handling of that child and possibly the prevention of bad habits of mental hygiene.

Occasionally, even with the best correction, the child's vision powers are still not such as to enable him to carry regular school work safely. Where there are a sufficient number of cases of this type, a special class may be necessary. This would not be a class for the blind. It would be a class for children in whom it is particularly important to conserve sight. It is estimated roughly that where there are as many as 5,000 elementary grade children there may be need for a sight-saving class. Special equipment and a specially trained teacher are necessary. The child can study in the special room and recite with his regular grade. Such children should be admitted to the class by the attending ophthalmologist and kept under his medical supervision. For an individual child requiring this special help, information should be sought as to texts and other matters related to his needs.

The prevention of blindness and the conservation of vision among school children are joint responsibilities of the official health and education agencies. The question of organization and procedure in inspection and follow-up care will be decided according to local conditions. Whether the outline be elaborate or very simple in scope, the first question should not be "Who has the time?" but rather, "How can time and skill best be used toward conserving the sight of the school child?"

## GOOD NEWS FROM MICHIGAN

The Michigan State Department of Health has received funds from its own appropriations and from the Rockefeller Foundation whereby it will be able to aid ten counties to organize county health departments, and it is recommending and urging that counties generally adopt this method of organization.

In order to provide the preliminary training in public health nursing required to qualify for the new positions, the State Department of Health is establishing a training station at Lansing, where essential instruction will be given followed by supervised practical experience in the field. The number of nurses who can be received for training at any given time is limited to five. Approved applicants will bear their own traveling expenses to and from Lansing, and will receive a stipend of $3 a day while attending the course. At the conclusion of the training, which lasts for a maximum period of ninety days, satisfactory candidates will be recommended to the positions which may be available either in this or other states. There will be no tuition charges.

# Report of the Committee on Public Health Nursing

## International Council of Nurses *

IN 1926 questionnaires were sent out to 19 members and 11 associate member countries; 24 were returned.

The information given here was obtained from the following countries:

| | |
|---|---|
| Belgium | Irish Free State |
| Bulgaria | Iceland |
| Canada | Latvia |
| Cuba | New Zealand |
| Denmark | Korea |
| Esthonia | Norway |
| Finland | Poland |
| France | South Africa |
| Germany | Sweden |
| Great Britain | Turkey |
| Greece | United States of America |
| Holland | |
| Italy | |

Public health nursing, as it stands to-day, still in the process of evolution, grew, in a number of countries, out of a District Nursing Service. This was the case in Great Britain, where it was started in Liverpool in 1859 by Mr. Rathbone, and in Sweden, Denmark and Latvia, where it was started by the Deaconesses between 1860 and 1870.

Canada dates its beginning of public health nursing from the establishment of the Victorian Order of Nurses in 1897; while in a number of other countries the start was made with child welfare work; examples of this are Finland, 1904; South Africa, 1908, and Greece, 1919. Other countries began with tuberculosis nursing, as, for example, Cuba in 1909 and Bulgaria in 1914.

### NUMBER OF PUBLIC HEALTH NURSES

The number varies—from a few nurses in Bulgaria, Iceland and Korea, to 1,200 in Holland, 10,000 in Great Britain, and 12,000 in the U. S. A.

They are engaged in:

Visiting Nursing
Child Welfare (including maternity)
School Nursing
Tuberculosis Nursing
Industrial Nursing
Mental Hygiene
Hospital Social Service

By far the greater number are doing visiting nursing and child welfare work. In some countries a fairly large number undertake tuberculosis nursing, while mental hygiene and hospital social service have not yet begun. This is true in countries where nursing on modern lines has only been begun within this present century.

### EDUCATION OF THE PUBLIC HEALTH NURSE

The preliminary general education of the public health nurse seems to be somewhat unsatisfactory. The U. S. A. is the only country where four years High School is generally aimed at. Belgium, Bulgaria and Cuba require some secondary education, while all the other countries seem to build mainly on a primary education, although it is almost universally stated that students with secondary education are given preference.

In regard to the professional education, Canada, Cuba and the U. S. A. require full training; the Irish Free State states that 99 per cent of its public health nurses are fully trained. Examples of the percentage of fully trained nurses in other countries are Belgium and Great Britain, 75 per cent; New Zealand, 65 per cent; Norway, 60 per cent; Italy, 35 per cent; Finland, 33 per cent.

### POST-GRADUATE COURSES

A number of countries have courses in public health nursing. In the United States and Canada a number of such courses are connected with the different universities. Cuba, Finland, Great Britain, Holland, New Zealand and South Africa, have courses of varying duration (2–12 months) con-

* Presented by the Chairman of the Committee, Mary S. Gardner, at the I.C.N. Congress, Montreal, July 13, 1929.

nected with various institutions or organizations. Some of these courses only teach the specialties such as child welfare work, or tuberculosis. Others offer courses in general public health nursing.

The percentage of nurses who have taken such courses vary; the percentage in the U. S. A. being comparatively small, where the number of nurses is large; in Canada, 50 per cent; in Finland, 88 per cent.

In Bulgaria and France the training in public health nursing is included as a part of the basic general training.

#### TYPE OF WORK DONE

The work in most of the countries is both generalized and specialized. Specialization is most common in urban work, and generalization in rural work. In the U. S. A., however, generalization is predominating. Specialization is most common in New Zealand and Poland. In Bulgaria, Cuba, Esthonia and Iceland practically only specialized work is found.

#### HOURS OF WORK AND VACATION

The weekly hours of work vary in different countries between 30, 33, and 35, which are respectively found in Italy, Greece, Cuba, and South Africa, to 60 and 65, which are found in Norway and Iceland, variation being found within the countries themselves.

Vacations range from ten days (Great Britain and Italy) to six weeks (Belgium, Norway, South Africa and Irish Free State).

## REPORTS ON PUBLIC HEALTH NURSING ACTIVITIES INTERNATIONAL COUNCIL OF NURSES *

#### BRAZIL

There is a permanent Bureau of Nursing in the National Department of Health subdivided into the Division of Public Health Nursing and the Division of Nursing Education. All public health nursing in the Bureau of Child Hygiene, Tuberculosis, Communicable Diseases and Venereal Diseases and Leprosy of the National Department of Health, comes under the Division of Public Health Nursing. Under the Division of Nursing Education functions the D. Anna Nery School of Nursing. The Division also is responsible for nursing care in such wards in the Hospital Geral de Assistencia, in a hospital for infants, operating under the Federal Bureau of Child Hygiene, and in a hospital for tuberculosis and acute communicable diseases operating under the respective bureau as required for the training of students. It is planned that as soon as the number of graduate nurses justifies the expansion, all nursing service in the four hospitals operating under the National Department of Health with an approximate capacity of one thousand beds will come under this Division. Salaries paid to those graduate nurses compare most favorably to those paid to women in the other higher professions.

No effort has been spared to build a solid foundation for the profession of nursing in Brazil. At times it has been necessary to compromise with the needs of the moment but never was the objective of the establishment of a strong profession of high standards lost sight of.

The one big task of the immediate future is to secure state registration for nurses that will classify the requirements for instruction and define clearly the status of the graduate nurse. There is reason to hope that this can be accomplished within the near future.

#### HUNGARY

In Hungary, both nursing and public health nursing are yet in a rather evolutionary period, but the prospect of the future is more than promising.

* With the exception of Brazil, which was admitted as a member at this Congress, these are excerpts from reports of some of the countries which are not yet affiliated with the I.C.N. Reports from the affiliated organizations were printed in September. The reports were given at the Congress, Montreal, Canada, July 11, 1929, and may be obtained from I.C.N. headquarters.

The most important step in advancing public health nursing will be undertaken by the Ministry of Public Welfare with the aid of the Rockefeller Foundation, by the opening of a Training Center for public health nurses, to be fitted to do generalized work of the highest possible grade. The Training School will function as one of the Departments of the State Hygienic Institute, which latter is responsible also for the post-graduate training of Medical Officers of Health. It will be a purely educational institution, related to a hospital only as far as the hospital serves as a teaching field for the nursing part of the training.

Public health nurses in Hungary do not undertake bedside care in the homes. In case of necessity they will teach some member of the family how to give simple care. It is also in prospect to have regular home-nursing classes in communities where a public health nurse starts work. There is also no such pressing need for giving bedside care. The country is relatively small and hospitals are easily reached. People have no antagonism toward going to hospitals and having beside three of our medical faculties in provincial towns, the institutional care of the sick is greatly facilitated and made rather appealing to country folks through these "University Clinics" as the hospitals of the faculties are called. It is obvious that very few people would need home care.

Furthermore, every community being compelled to employ a qualified "village midwife," maternity care is secured for even the humblest one.

The field work in public health will be provided for in County Health Units, organized especially for that purpose, viz., to serve as a teaching field for both health officers and public health nurses.

**PALESTINE**

Palestine is an important center for the training of nurses in the Near East. The policy of the Government has been to encourage the training of Palestinian women of all creeds. The country is fortunate in this respect. In some of the neighboring lands it has been found impossible to get the girls of the country to take up nursing as a profession. Among the Moslems, the social class from which nurses should be taken, is an aversion to girls undergoing training. In Palestine, however, the daughters of good families more readily take up the work, and the Palestine girl, properly trained, makes an efficient and responsible nurse.

Further, a demand has sprung up in the neighboring countries for nurses trained in Palestine, partly, no doubt, on account of their own lack of nurses but to some extent because of the good standard of knowledge and ability of the girls who have gone from Palestine to act as staff nurses, etc., in hospitals elsewhere. Thus, within the last three or four years, Palestine has supplied nurses to Egypt, Syria, Transjordan, Turkey and Iraq.

**SYRIA**

At the School of Nursing of the American University Hospita' at Beirut—until now the only school of nursing in Syria—there is the complete setting for a university course and there appears to be no reason why it should not materialize in the near future. The old prejudice that nursing is menial and too hard work for young women of a high social status still has to be combated. Education and higher courses are very popular among the young people in Syria and we hope to prove to them that in nursing they are getting a certain amount of liberal education and a very valuable preparation for life.

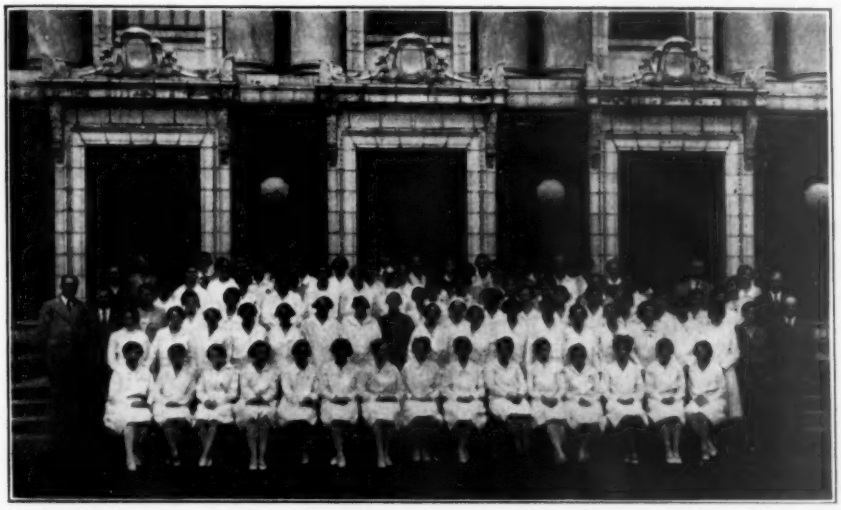
A year ago it became possible to open a Health Center near the University. There is an American nurse in charge, with a Syrian nurse assisting. In connection with this it has been possible to do a great deal of follow-up work from the hospital, and to take over the regular inspection in several schools for native children.

**URUGUAY**

*Infant Welfare Service.* This includes a registry for wet-nurses, nurseries, crèches, "gouttes de lait" (milk-kitchens), etc. There are four supervising nurses and excellent work is being done by the nurse in charge, Senorita Pujado, who is admirably fitted for this work by her professional preparation and her capacity for organization.

There is no organization for public health nursing. Four nurses, however, are engaged in this work, although they have received no special training; two of them work in an infant welfare center, one is employed by the Uruguayan League against cancer of the uterus and another in maternity homes.

## SCHOOL NURSING COURSE



*Nurses enrolled in School Nursing Course, State Teachers College, Buffalo, N. Y., 1929, with faculty and administrative officers*

The course for school nurses given last summer at State Teachers College, Buffalo, under the auspices of the Education Department, State of New York, was unusually successful and well attended. Seventy-three nurses registered, all of whom had had experience in the field. Miss Marie Swanson, A.B., R.N., State Supervisor of School Nurses, was in charge of the course, which included "Principles of Teaching," "Methods and Presentation of Home Hygiene and Care of the Sick," and "Practice Teaching." A small summer practice school was attached, representing three grades only. College credit was given for the course. A thorough physical examination was given every student.

One of the valuable features of the course was class assemblies without speakers. Demonstrations of tests and morning inspection with opportunity for practice were offered to those feeling the need of it.

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The Silver Trophy offered each year by the National Negro Business League, for the best country-wide negro health campaign carried on in any rural community in the entire country, in connection with the celebration of the annual Negro Health Week of the current year, has been awarded to Anne Arundel County, Maryland. This is the third time the award has come to Maryland. The work was done under the direction of the Deputy State Health Officer, assisted by the public health nurses in the county, Miss Margaret C. Wohlgemuth, Miss J. Irene Kauffman, and the officers of the Maryland Tuberculosis Association.

The trophy—a handsome silver vase—will be shown at the colored schools and at public meetings in the county during the coming year.

# Red Cross Public Health Nursing Service

*Excerpts from Annual Report* *

By Elizabeth G. Fox

National Director, Public Health Nursing Service, American Red Cross

A YEAR ago announcement was made in the pamphlet "What the Future Holds for Public Health Nursing under the American Red Cross" of a shift in policy for the next decade resulting from our experience in the first decade of post-war service just ended. The most significant change lay in the substitution of a policy of permanent participation in the public health nursing work of the community for the old policy of demonstration only.

### EFFECT OF CHANGE IN POLICY

The psychological effect of this new policy, which the Chapters have accepted with general approval and in many places with enthusiasm, has been most stimulating. Recognizing their increased responsibility they have proceeded to take their work more thoughtfully and to study it more analytically with a view to future development. This has had a very wholesome effect on our Services as it has changed the whole atmosphere from one of somewhat casual and transitory interest to one of genuine seriousness of purpose and constructive building.

In spite of its importance the new policy has aroused little comment from the outside and that little almost unanimously favorable. Exceptions should be noted, however, in two directions. As yet, no satisfactory basis has been found for partnership between a Chapter and a County Health Unit in the conduct of a joint nursing service, as the Health Officer in the Unit usually insists on concentrating all authority in his own hands while the Red Cross takes the stand that financial participation should be accompanied by a due measure of control over the work paid for.

### TWO THEORIES OF CONTROL

Two theories of government are here in friendly conflict. One is substantially that public health work is a governmental responsibility exclusively and that the activity of voluntary agencies is necessary and desirable only until the government can secure sufficient appropriations to do the work itself. In accordance with this theory the Units, while willing to accept and indeed often seeking money and moral support from the voluntary agency, believe it unsound to allow the voluntary agency anything more than advisory status. The State, it would almost seem, is greater than the people for whom the State exists.

The other theory is that the government, while it has many advantages in the performance of public health work, also suffers many handicaps which are not encountered by the voluntary agency; that these handicaps can in a measure be overcome by joining the two in a partnership which requires a real sharing of ideas, of labor and of responsibility. According to this theory the people do well to provide themselves with public welfare service both through the regular official channels of government and through the freer and more flexible channels of voluntary association. And partnership between these two, the voluntary agency and the government, in the joint conduct of public health nursing because it tends to combine and accentuate the best features of each and to neutralize their weaknesses is highly desirable. Moreover, joint control is quite possible without deflecting the Unit from its path if there is a generous spirit of respect and trust on both sides.

That such a partnership in localities

* The full report will appear in the *Red Cross Courier* for October.

where there is no Unit is popular is evidenced by the steadily increasing tendency for the county or town to join with the Chapter in carrying on a public health nursing service. Beginning with a mere handful of such joint enterprises the Red Cross Public Health Nursing Service is now a partner with the public authorities in 413 different counties, an increase of 20 over last year. At the same time the trend, so marked a few years ago for the public authorities to take over the service entirely after a period of partnership, is slowing down as shown by the following table of services taken over entirely by the public authorities from our Chapters:

| | |
|---|---|
| 1925–1926 | 70 |
| 1926–1927 | 61 |
| 1927–1928 | 35 |
| 1928–1929 | 19 |

We believe this is a sound change in trend just so long as our Chapters meet their responsibilities creditably. Furthermore, it sets us to wondering whether a much stronger alliance is not both possible and desirable between the American Red Cross and our State governments in the field of health such as exists in the field of disaster.

The other of the two exceptions we noted lies in the doubt occasionally expressed of the ability of our larger Chapters to continue with the steady development of a city service as well as an independent local agency might, once the service passes out of its infancy and faces the need for rapid expansion both in volume and scope. That this is a real question in some places we admit.

On the other hand, the large majority of our Chapters which have growing city services are doing so well that there is no ground for questioning their present leadership or for predicting that they cannot keep up their present pace. The answer to this doubt which has been expressed by one or two seems to be, therefore, that there is nothing inherent in the Red Cross as an institution constituting an insuperable obstacle to the satisfactory performance of community service, such as public health nursing, but that there may be an occasional Chapter too handicapped for one reason or another to be able to keep up with the demands of the community for increasing service. In other words, the wisdom of a policy of permanence in the larger centers must be decided for each city on the merits of the particular situation.

### ITINERANT NURSING A SUCCESS

That the scheme of itinerant nursing is serving its purpose of providing a measure of public health nursing for the counties which have too meager resources to afford a full-time service is clearly evident in the increasing number of part-time services. Last year there were 60 of these services; this year 88. In 55 of these the Chapter has been able to raise the necessary funds unaided, but in 33 it has taken the combined efforts of the Chapter and the local authorities to scrape up enough money for the two, three or four months service. Another proof of the success of this plan lies in the fact that the majority of the Chapters are repeating the service year after year and some of them are increasing the length of time the nurse is with them. There are, we suspect, not less than 500 counties too poor to afford more than a part-time nursing service. At present we are meeting only a fraction of this need and should not be content until there is an itinerant nurse in every such county.

### WHAT THE NURSES ARE DOING

It may be worth recording the principal activities of the nurses at the present stage of our work. School nursing on a county-wide basis still remains the primary activity in a great majority of the middle western and far western states, while visiting nursing holds first place in the town services in the eastern states. Among the lesser activities two stand out in particular. The slogan to free our children from diphtheria has been spread all over the country by State Departments of Health and many of our nurses have had much to do with the actual work

of getting the children immunized. As we think of the hundreds of thousands of homes protected from this dread disease we realize what a blessing this activity has been.

Another activity that is taking a prominent place in summer programs is the Summer Round-Up. Our nurses everywhere have joined hands with the Parent-Teacher Associations and the doctors in undertaking to have as many as possible of the younger children made physically fit before their entry into school life.

A small beginning has been made in providing hourly nursing and nursing care during confinements by a few of our Chapters. We hope to see steady growth in both of these directions.

The plight of the country family in time of sickness has given us much concern. Visiting nursing, taken for granted in the cities, is available in only a very few rural counties, for those living in the country. The size of the county and the distance between homes makes it almost impossible for one nurse working alone to meet the need even though her whole time is given to visiting nursing. And the cost of visiting nursing is excessive for the voluntary agency as no aid is forthcoming for this type of work, as a rule, from the public treasury. These two handicaps have so far steadily barred our way from developing a country visiting nurse service. We are anxious to try it out as soon as one of our rural Chapters feels that it can afford to make a beginning.

As yet unsolved is the question of what to do about the problems in mental hygiene, nutrition and social service the nurse constantly encounters in her work when the county does not see the need of or cannot afford the service of specialists in these fields. We are beginning to think that perhaps the nurse will have to be trained to do the simpler things in these fields as soon as consultant specialists are provided by the state to diagnose and prescribe treatment and to guide the nurse in the follow-up work.

On June 30th of this year we had 603 services and 766 nurses, a good start on the upward curve. The fact that we have done a little better than hold our own, however, does not interest us for its mere increasing bigness; our satisfaction comes from our conviction that this is proof of the increasing interest and competency of our Chapters and nurses.

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A meeting of Red Cross nurses, called by the League of Red Cross Societies to advise the Nursing Division with regard to some of its problems, will be held in Paris, October 24 to 26. Of chief importance on the agenda will be a consideration of a study, prepared by the Nursing Division from replies to questionnaires sent to all the national societies on "The Enrollment of Nurses" and "The Training and Enrollment of Nurses' Aids." Miss Elizabeth Fox will represent the American Red Cross and has been invited by the League of Red Cross Societies to make study visits before the meeting in Italy and Belgium. Miss Fox will also meet the present students of the International Courses in London.

The Red Cross nurses invited to attend this meeting are: Mme. Chaponnière-Chaix, International Red Cross Committee; Marchesa di Targiani Giunti, Italy; Mlle. d'Haussonville, France; Mme. Ibranyi, Hungary; Miss von Freyhold, Germany; Mlle. Kaeckenbeeck, Belgium; Mlle. Chaptal, President, and Miss Reimann, Secretary, International Council of Nurses.

# Better Planning—Better Results in School Nursing *

By Robina Kneebone, R.N.
Director, Courses in Public Health Nursing, William and Mary College, Richmond, Virginia

"WELL begun is half done," could be applied to school nursing if each school nurse would take the time to study the needs of her community and attempt to understand local problems. Yet much valuable time is lost performing routine measures that should have been discontinued or minimized long before the present nurse's occupancy of the school nursing position.

### KNOWING THE LOCAL SITUATION

To know the local situation as a school nurse involves:

A definite study of all past programs of school nursing in your district.

Decision as to whom you are directly responsible for your program—the superintendent of schools, school physician, or are you classed as a physical supervisor and thereby permitted to plan your own program through *close coöperation with all the other departments in the school system.*

A knowledge of the specific needs that exist in your community.

Definite aims and objectives that you have learned are desirable in a school nursing program or the progressive objectives that you personally desire to accomplish during your term as school nurse.

With such an understanding of your work, gone are the days of the attendance officer and first aid school nurse.

The procedure of building upon the positive good work of a predecessor, or laying the foundation of a sound school nursing program is much the same. First, *gain and retain interest* in your plans, one at a time. Begin with a unit of work small enough that results may be measured in a given period of time and within the range of accomplishment of the average individual with whom you work. Upon completion of action *measure results* and *record them.* To illustrate:

Suppose a community campaign for toxin-antitoxin clinics is your objective. Arouse your community interest in 100 per cent immunity for the children. Recall New York's slogan: "No Diphtheria by 1930!" Determine your goal! Let us assume it is the first time a T.A.T. Clinic has been held in that community, and all children from one year to ten years are eligible for protection against diphtheria. How many children are there from one year to ten years? Consult the school census and attendant records, get the yearly birth figures and you find that there are 650 children. How many have already received toxin-antitoxin and had a negative Schick after-inoculation? Deduct that number from 650 and assume that 600 children is the answer.

You can plan and wage an educational campaign through consent slips, talks to teachers, pupils and parents; moving pictures; classroom devices and competitions; and newspaper publicity. This campaign is the combined effort of local doctors, women's clubs, parent-teacher associations, school board, and nurses. The clinics are held at the school houses, and five weeks are consumed by the campaign and 450 children receive toxin-antitoxin. You secured 75 per cent of your quota.

Very good! But *why* didn't you get the other 25 per cent? Was the clinic poorly advertised? Did you encourage mothers to bring preschool children or did they create too much disturbance? Were school children the main beneficiaries of the clinic? At what age is the death rate highest from diphtheria? Would a few extra home visits have reduced opposition in a given locality? What age group did you reach most successfully? Was there any school group, racial group, or social class group that failed to avail themselves of the opportunity of the clinic? By answering your own questions you have planned your next year's clinic program.

### TAKE THE TEACHER INTO PARTNERSHIP

Other aims are less direct and more intangible results exist. Increased interest on the part of the teachers is a most laudable accomplishment. *Take the teacher into partnership in the health game,* and express your pleasure

* Abstract of paper in *Minnesota Public Health Nurse,* June, 1929.

when she secures results. Measure pupil and parent interest whenever and wherever it becomes apparent.

These objectives might reasonably be included in a program:

Health education for all grades—with special emphasis on junior and senior high school problems.

Decreased absence due to contagion.

Increase of general average attendance.

Decrease in amount of remedial work, such as dressing of cuts and minor infections, accidents and the like. Teach the cause and prevention at the same time you apply the remedy.

Teach cleanliness and *honor correction* of *defects.* Don't be satisfied with discovery of dirt and noting number of defects. Recording defects without correction of the same as the goal will accomplish little or nothing.

Aim to improve building sanitation, lighting and ventilation from year to year.

Educate the proper individuals to the need of adjustable desks and individual seating of children.

Execute regular weighing and measuring, and carry it forward to a weight improvement campaign. Teach nutrition facts, record your results.

Encourage the children themselves and their teachers to take part in measuring individual, classroom, building, family and community health accomplishments. It is a fine way to teach the value of health.

Plan your program to meet the needs of your situation. Use all of the old measures that have been known to bring results. Add new aims and methods that have been tried out elsewhere and have brought results. Lastly, experiment by trying out something new for your community. Don't be afraid to cultivate the research habit. Prevent rather than cure. Teach rather than correct. Make the school nursing program part of the wider goal of *improved community health.* "Not what you are but what you may become."

## THE 1930 CALENDAR

This is an illustration from the 1930 Calendar of the National League of Nursing Education. The two robed figures are medieval saints casting out the devils from the city—an obsolete form of public health nursing. In fact, the illustration is from the page picturing public health nursing, ancient and modern. The calendar this year features contrasting nursing methods which are not only instructive but also entertaining, and you will want to frame the frontispiece—the modern temple of healing—the new Medical Center, beautifully tinted in colors.

Orders for the calendar should be sent to the National League of Nursing Education, 370 Seventh Avenue, New York City. The calendars are $1.00 each, seventy-five cents for lots of fifty or more. The proceeds of the sale help maintain and develop the work of the League.

# Report of the American Home Economics Association Convention

The American Home Economics Association held its twentieth annual convention at the Hotel Statler, Boston, Massachusetts, July 1–5, with a record attendance of 1,350. The field of home economics is very new compared to that of nursing, but even in the twenty years of its existence diversified interests have led to the formation of the following sections: teachers, extension workers, women in business, and home makers. There is also a small but active group of nutritionists working in family relief or public health agencies.

Sweden, Belgium, South America, and Switzerland were the foreign countries represented at the convention and there were also many Canadians.

All of the meetings were unusually good, but those which would especially interest nurses were the round table on research, the talk by Dr. Percy Howe of Forsythe Dental Clinics in which he stressed the relation between a well-balanced diet and good teeth, and the paper of Dr. Marianna Taylor who stressed the need for understanding present day youth and the difficulty of adjusting them to the family group.

At the Social Service Section three papers were given on the nutritionist. Miss Florence Patterson, Director of the Community Health Association of Boston, spoke on "What the Home Economist Can Contribute to the Public Health Nursing Field," Miss Bertha Edwards, Nutrition Supervisor of the East Harlem Nursing and Health Center, on "Additional Training the Home Economist Needs to be an Effective Social Worker," and Miss Lucy Gillette, Nutrition Supervisor of the Association for the Improvement of the Condition of the Poor, on "What Type of Case Should Be Referred to the Home Economist."

Miss Patterson discussed the improvement in nutrition teaching in her own organization due to the influence of the nutrition worker. She feels that the greatest need of nutritionists in the field is for definite objectives, for some "yard-sticks" with which to measure the value of methods, the development of standard techniques and accurate estimates of unit costs. She feels that further progress in a nutrition program for the public health nursing field depends on two things: first, how far the present education of nurses in dietetics in training schools can be extended so that nurses will enter the field better prepared; and second, the further education of the nutrition worker in public health science and administration. She feels, however, that the place of the nutritionist is firmly established.

Miss Edwards in her paper stated that the nutrition worker's training should enable her to:

1. Teach by use of sound teaching principles.
2. Study methods of research.
3. Outline and execute a research program.
4. Plan and execute work.
5. Appreciate use of statistics in planning program.
6. Recognize the value of coöperating with people in the organization and community.
7. Add to the teaching knowledge of co-workers.
8. Teach families and be able to adapt her teaching to racial customs.

Miss Gillette, speaking from the point of view of a family relief-giving agency, believes that the work of the home economist depends on the policy of the organization, that is, whether it is extensive or intensive, group or individual, for sick or well patients. When there are few workers, the nutritionist should act as advisor to the social worker or nurse who is carrying the case. If there is time, there should be home visiting for specific problems, for example, prenatal or malnutrition. In a big organization the nutrition worker could carry the family as a whole to save expense. If the social worker is to carry nutrition cases, more social workers will be needed, it would seem logical to add more nutrition workers at the same cost and have the benefit of specialists. The social workers and nurses have so many specific problems that the nutrition problem is often ignored.

*Blanche F. Dimond, Nutrition Supervisor, Boston Community Health Association*

# ACTIVITIES *of the* NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING, INC.

*Edited by* KATHARINE TUCKER

*Alma C. Haupt, Associate Director*

*Edna L. Moore, Assistant Director*

*Underwood and Underwood*

*Evelyn K. Davis, Assistant Director*

INTRODUCING NEW MEMBERS OF THE N.O.P.H.N. STAFF

# DEFINITION OF NURSING SERVICES

*Foreword: The following statement has been prepared by Louise M. Tattershall, N.O.P.H.N. statistician, in coöperation with the N.O.P.H.N. Records Committee and N.O.P.H.N. staff as part of a Manual on Statistical Practices of Public Health Nursing Agencies. This manual is the work of a joint committee of representatives of the N.O.P.H.N. and the Committee on Registration of Social Statistics at the University of Chicago. These definitions are important as they form the basis for reports in public health nursing. The N.O.P.H.N. Records Committee still has under consideration the application of them to the various phases of public health nursing and will amplify the definitions to meet problems as they arise.*

## PUBLIC HEALTH NURSING

**Public health nursing is an organized community service not for profit, rendered by graduate nurses to the individual, family, and community. This service includes the interpretation and application of medical, sanitary and social procedures for the correction of defects, prevention of disease and the promotion of health, and may include skilled care of the sick in their homes.**

Public health nursing may be administered by official or non-official agencies, or may be administered jointly by official and non-official bodies.

The nursing service rendered by agencies engaged in public health nursing may be classified, according to the nature of the problems presented, as follows:

1. Health Supervision Service
2. Maternity Service
3. Morbidity Service

or by special groups in the community, such as:

(a) School Nursing Service
(b) Industrial Nursing Service

The nursing care under the services may be given during visits to the individual under care; during visits of the individual to a conference or a clinic; through visits made in behalf of an individual; and through group instruction in classes, clubs, and meetings.

In addition to these services agencies may carry on from time to time special activities, which are not a part of the continuous program of their nursing services.

## HEALTH SUPERVISION SERVICE

**Health Supervision Service is the continuous supervision of the health of supposedly well individuals of any age group (exclusive of communicable disease contacts and suspects and maternity cases), whereby the individual is seen at intervals and instructed on the basis of or pending medical examinations as to the best measures for the promotion of his health.**

In addition, agencies doing "family health work," where the health of members of the family, other than those carried for maternity or morbidity care, is kept under supervision for a period of time and where case records are made out for such individuals, may be said to be giving a Health Supervision Service.

Cases carried under these conditions may be members of a family, who appear in need of medical care, and who are carried until medical examination and diagnosis can be obtained.

The supervision relates to such aspects of health as the nutrition of the individual, formation of habits of personal hygiene, clothing, exercise, rest, social and mental adjustments, and the observing of physical defects and the overseeing of their correction according to medical advice. The service may be rendered through conferences under medical or nursing direction; through classes and clubs, field visits, or combinations of these. The classification under this service is by age group, as follows:

Infant: under 1 year.
Preschool: 1 year of age and under 6, if not in school.
School: 6 years of age and those within the limit of compulsory school age as defined by state law, and other minors in school.
Adult: all beyond the limit of compulsory school age as defined by state law, if not in school.

### MATERNITY SERVICE

**Maternity Service includes nursing care given during pregnancy and delivery, and care given to mother and newborn after delivery. The care given includes instruction as to health habits, nutrition, and other factors bearing on the general health of the prospective mother; preparation for the baby; attendance at delivery; actual care of the mother and baby after delivery or instruction as to their care, and general supervision of their general health. Agencies do not necessarily give care of all these types, but nursing service rendered in relation to any one should be included under Maternity Service.**

The care given during pregnancy is called Antepartum or Prenatal Care.

The care during delivery is called Delivery Care.

The care given to the mother after delivery is called Postpartum Care or Postnatal Care.

The length of this later period is terminated at the time of postpartum medical examination or at the end of six weeks after delivery.

Care given to the newborn infant in connection with the postpartum care of the mother is called Newborn, or Neonatal Care.

### MORBIDITY SERVICE

**Morbidity Service, which is often called bedside nursing, is concerned primarily with the care of sick persons under or pending medical direction, but it also includes as an extension of its work with cases of communicable disease the supervision of persons who are suspected of having, or who are known to have been exposed to, a communicable disease. The nursing is not limited to sick persons confined to their beds, but is given to ambulatory patients as well. The care is not only actual nursing, but includes instructions as to health habits, nutrition, and other factors bearing on the general health of the individual nursed. It may also include needed service during the period of convalescence.**

This service is classified under Non-Communicable Disease Nursing and Communicable Disease Nursing. There may be further classifications under these two headings, depending on the nursing program of the agency.

*Non-Communicable Disease Nursing:*

This service includes the nursing of all diseases not listed as communicable by the local board of health.

The sub-classifications "Acute" and "Chronic" are not recommended for current reporting, because of the difficulty of determining what is to be included under "chronic" diseases, and because of the fact that the nursing care of chronic diseases does not differ in any marked degree from that of acute diseases.

For agencies wishing to make these sub-classifications:

Chronic cases are those designated as such by the attending physician, or cases which have been under care or likely to be under care for a period of 3 months or more.

*Communicable Disease Nursing:*

This service includes not only the nursing of all diseases listed as communicable by the local board of health, but also the supervision of individuals who are suspected of having, or who are known to have been exposed to, a communicable disease.*

The service rendered may be primarily instructive and regulatory, with actual care of the patient given for demonstration only, or in an emergency. The nurse may act as the designated official representative of the health department in regard to instructions as to quarantine regulations and to the control of cases and contacts of communicable diseases.

* The application of the last part of this statement to chronic communicable diseases, as tuberculosis and venereal disease, is still being considered by the N.O.P.H.N. Records Committee.

The service rendered may also be the actual nursing of cases of communicable diseases with instruction as to the best means for prevention of further infection.

### SERVICES TO SPECIAL GROUPS

Where the nursing care given by an agency is confined to special groups in a community, the classification may be on the basis of the group to receive care, rather than of the special health problem presented. The nursing care given to these particular groups may include all or only one of the phases of nursing services previously described.

Under this heading of Services to Special Groups will come School Nursing Service, Industrial Nursing Service, and services to other special groups.

### SCHOOL NURSING SERVICE

**School Nursing Service includes activities in relation to school work in behalf of children in public or private schools.**

These activities are concerned with the health of pupils and school personnel; the securing and maintaining of a healthful school environment; and the promotion of an adequate health program in the schools. They must be a part of the official program of the local school board. Moreover they are carried on within the school building and properly include in addition the follow-up necessary in the community outside the school building.

A complete report of a School Nursing Service will include all activities carried on within the school building and such activities carried on outside of the school building as are an integral part of program of school nursing. The activities may be classified as:

1. Activities within the school building.
2. Activities outside the school building.

### INDUSTRIAL NURSING SERVICE

**Industrial Nursing Service includes activities in behalf of the health of employees of commercial and industrial concerns, initiated within the industry. It may be given to employees only within the establishment, or it may be given outside the establishment to employees or to employees and their families.**

A complete report of an Industrial Nursing Service will be of those activities carried on within the establishment and such activities outside the establishment as are an integral part of the industrial nursing program. The activities may be classified as:

1. Activities within the establishment.
2. Activities outside the establishment.

If the program of industrial nursing is confined to activities within the establishment, the report of Industrial Nursing Service will be of those activities only.

It is recommended that agencies which have contracts, directly with industries or through group insurance plans, for giving care in the home to employees or employees and members of their families, continue the present practice of including the report of the care given to these cases with that of the Maternity Service or Morbidity Service.

### CONFERENCES AND CLINICS

**Conferences and Clinics are meetings arranged for at a definite time and place for examination, inspection, or treatment of cases, and the individual discussion of health problems or disease conditions and involve the making of individual case records.**

Conferences are usually for the well and may be either medical or nursing, depending on whether a physician or a nurse is in charge.

Clinics are usually for the sick and are always in charge of a physician.

#### CLASSES, CLUBS AND MEETINGS

**Classes, clubs and meetings are assemblages arranged for at a definite time and place for the purpose of group health instruction and do not involve the making of individual case records.**

#### SPECIAL ACTIVITIES

**Special Activities are activities in relation to special projects of the agency, which are not an integral part of the continuous program of any of the Nursing Services, or are in relation to a project carried on for some other agency or to some special service rendered for another agency or individual.**

Some of the special projects which an agency may undertake, either as part of general program of the agency or at the request of outside agency are:

a. Summer round-up of preschool children.
b. Visits to interest parents, where no case is under care, in immunizations, etc.

Some other services which an agency may be asked to render for another agency or individual are:

1. Visit at request of a hospital, to find out why an individual has not returned to a clinic.
2. Visit at request of a physician to an ex-patient for report on condition.

The report on Special Activities will be classified as:

1. For organization.
2. For other agencies or individuals.

The sub-headings under these two headings will depend on the nature of the activity.

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## LISTING CASES HAVING MORE THAN ONE CONDITION REQUIRING CARE

*Recommendations of N.O.P.H.N. Records Committee*

When a more acute, or probably less lasting, condition arises in an individual carried as a case under any of the three nursing services, Health Supervision, Maternity, or Morbidity, the case is carried under the diagnosis of the more acute or probably less lasting condition.

(a) When the more acute condition is cared for by a nursing service, other than the one under which the case is being carried, the case is transferred from the present service to the service where the more acute condition is cared for. It is entered as a new case, carried, discharged and analyzed as part of this second service. After dismissal from second service, it is readmitted to the first service and carried.

#### EXAMPLES

An individual carried as a case under the Health Service develops pneumonia or some other acute morbid condition:

This case is transferred from the Health Supervision Service to the Morbidity Service and entered as a new case under this service. It is carried, discharged and analyzed for report of Morbidity Service. At dismissal from Morbidity Service, it is readmitted to the Health Supervision Service.

An individual carried as a case under Maternity Service develops typhoid fever or some other acute condition, which is not a complication of the maternity condition:

This case is transferred to the Morbidity Service and readmitted to Maternity Service when discharged from Morbidity Service.

An individual carried as a tuberculosis case under the Morbidity Service becomes pregnant. The case is transferred to Maternity Service and readmitted after discharge to Morbidity Service. If the diagnosis of tuberculosis is made for the first time in an individual carried as a Maternity case, the case continues to be carried as Maternity case until the end of Maternity care and discharged. It is then entered as a new case in the Morbidity Service with the diagnosis of tuberculosis.

(b) When a more acute condition arises in an individual carried as a case under the Morbidity Service, the case should be carried under the diagnosis of the more acute condition.

GENERAL RULINGS

1. An acute condition takes precedence over a chronic condition.
2. Infectious and communicable diseases take precedence over any other disease.
3. Acute communicable diseases take precedence over a chronic communicable disease.

A new diagnosis of a more acute condition will be a new case and have a new case record only when the new diagnosis is one that would not usually arise out of or follow the first condition. The following will be considered new cases:

1. An individual with a diagnosis of tonsillitis breaks a leg.
2. An individual with a diagnosis of tuberculosis develops scarlet fever.

If the first condition is a condition needing care for a short time only, as in (1), the case is dismissed under the first diagnosis and analyzed. It is entered as a new case under the second diagnosis with a new case record, carried and analyzed.

If the first condition is a chronic condition, the case is transferred to the new diagnosis, entered as a new case with a new case record. It is discharged and analyzed under the second diagnosis, and readmitted under diagnosis of chronic conditions.

## PROGRESS REPORT, N.O.P.H.N. SERVICE EVALUATION COMMITTEE

The Service Evaluation Committee, which some of our readers will recall as the former advisory committee for the Report of the Committee to Study Visiting Nursing, has for the last two years been considering the revision of the report, particularly a revision of the section dealing with the cost of a nursing visit. Questions and problems arising out of the present method of computation of cost have presented difficulties calling for a reconsideration of some of the recommendations. Also the fact that the first edition of the Report is exhausted has made reprinting and therefore revision imperative.

The Committee, therefore, has planned an extensive time study of public health nursing services in twenty-four cities (of these about half will be in small associations) which will be carried on for three months during the winter of 1929–30. The material so gathered will serve as the basis for further consideration of the method of cost computation. The cost of this study is being met in part through the generous coöperation of the Metropolitan Life Insurance Company and the John Hancock Mutual Life Insurance Company. It is hoped that the report and interpretations of findings will be ready for publication by the fall of 1930.

Our members are reminded that the undertaking of this study does not in any way change the function of the Service Evaluation Committee, which, as defined by the N.O.P.H.N. Board of Directors, is as follows:

The Service Evaluation Committee shall act in an advisory capacity on all questions bearing upon the evaluation of public health nursing services, rendering upon request interpretations of the 1924 study as later amended and approved by the N.O.P.H.N. Executive Committee and shall formulate and submit to the Executive Committee for approval any new interpretation or definition of policy.

This committee will prepare study or research projects designed to serve as a basis for more accurate statements as to cost and content of nursing visits. In controversial questions between local services and contracting parties the committee will give an interpretation in terms of policy, the local application of which will have to be decided by those immediately concerned.

DOROTHY DEMING, *Secretary to the Committee*

# BOARD AND COMMITTEE MEMBERS' FORUM

*Edited by* VIRGINIA BLAKE MILLER

Board Member, Instructive Visiting Nurse Society, Washington, D. C.

## THE CITIZEN AND PUBLIC HEALTH

Dr. Helen R. Y. Reid, President, Montreal Child Welfare Association, in her paper on "The Citizen in Relation to the Public Health Program" presented at the International Council of Nurses, Public Health Section, July 11, 1929, dwells on the desirability of increasing coöperation between public and private agencies interested in public health, and says in part:

The citizen has a contribution to make, whether he be found in the health field as patient, or as volunteer on the boards of health associations, as doctor, nurse or director of a public health organization, or again as public health official with governmental authority. On the world's health stage everyone is citizen, and each in turn must play his part!

The volunteer's contribution may be in the form of active participation in some of the local or national nursing services, mental or social hygiene councils, child welfare centers and guidance clinics, in parent-teacher groups, health, education and recreation associations, work for crippled children, occupational therapy, fresh air camps and the like. As presidents, board directors and committee members, their duties are manifold. These include, not only the raising and administering of funds, but also representing the organization and interpreting to the subscribing public its functions and the part it plays in the larger health program of the community. We also find men and women of vision and courage demonstrating the need of new health-giving measures and under professional direction establishing and carrying on such work. In addition, the volunteer is frequently doing specific supplementary duties, such as clerical and motor service, writing reports, speaking, interviewing, etc. This active participation by the volunteer citizen discloses the importance of the definition of relationships between him and his professional partners if the work undertaken is not to be hampered by mistakes due to overzeal, indifference, ignorance or lack of coöperation. Possibly the time necessarily spent in the past on building up the technique of professional standardization, procedures and routine, in adjusting relations between the various nursing and medical professions, might now be spent, in part at least, in developing the technique of working with volunteer committees and with the official representatives of public health in the community. Active participation also develops the sense of partnership, of team play which goes so far towards the realization of a true community consciousness, the desired aim and end of all organized community work.

Public and private or voluntary health organizations exist side by side today in most civilized countries. The citizen may be mystified by what at times appears to be an overlapping of activities, he may therefore be distressed at the apparent waste of time, thought, energy and money, particularly when he is finding it increasingly difficult to pay for medical and nursing care himself, but he must acknowledge that as a result of the organized application, both private and public, of the findings of medical research, nursing studies and preventive medicine, the life of the ordinary man has been lengthened by many years, and those years have been rendered more free from the terrors of communicable and other dread diseases. The citizen, in the last analysis, bears the burden of illness and pays for all health service.

In addition to this extraordinary evidence of voluntary effort, we note

the increasing number of Health Demonstrations. "These comprehend the health of the members of the community or the health of children, the prevention or treatment of a specific disease such as hookworm, or the testing a special method such as public health nursing of a specialized or general type."

In the light of history we can see the gradual emergence from primitive conditions of all forms of public authority and government, the individual citizen or citizens repeatedly taking the initiative with a courage sometimes born of despair and with truly heroic persistence in instituting reforms for safeguarding the life and well-being of the people. We acknowledge the present day need for increased division of labor, for specialization in science, for detailed and accurate research in medicine and public health, but are we not also acquiring more and more the sense of collective responsibility? Do we not feel that team play is needed, and that citizen, doctor, nurse and public health official are all partners in the great adventure of healthy living? We see both forms of health service—public and private, independent and collective, working side by side, at times with friction and without coöperation, at times displaying amazing success or inexplicable failure. We know that both ways have their rewards and both have their dangers. For certain purposes, at certain times, and given certain conditions, the enlightened citizen will recognize that the particular end in view requires independent specialization of work; and at other times he will see the need for synthesis, for generalization, for application of the facts to a collective purpose. "One of the deepest problems of the statesmen is to guide the communal coöperative evolution so that it does not involve jettisoning the rewards of competitive individualism."

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The President of the Board and Committee Members Section of Rhode Island, Mrs. W. W. Weeden, reporting the Institute held at Providence in May, said: "The Question Box brought out so many problems that discussion had to be continued in the afternoon." We quote the questions:

What training should a board member have before or after going on the board?

How can the coöperation of local physicians and visiting nurses be obtained?

What should be the initial salary of a nurse in a town of 4,000, generalized service, 8 schools and 18 square miles? On what basis and how soon should the salary be raised?

Should the nurse executive director be present for all of the board meetings?

Should a small organization take undergraduate students from a local hospital for training in public health nursing?

From whom should a public health nurse receive instructions? May she carry out instructions from any other source than from a reputable physician? What of instruction from insurance companies?

Does much friction exist between public health nursing units and the medical profession? If so, why? How can it be avoided?

How much in the line of service do we owe to our generous summer contributors when those months could well be filled with preschool and school follow-up?

How much of the details of the service should the board carry?

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Those interested in the Forum will wish to welcome Miss Evelyn Davis, who takes up her duties as secretary to the Board and Committee Members Section this month at the National Organization for Public Health Nursing, 370 Seventh Avenue, New York. The Forum hopes it may be of use to her as a means of communication with the Board and Committee Members Section.

# POLICIES AND PROBLEMS OF PUBLIC HEALTH NURSING

## HOLDING THE INTEREST OF THE PUBLIC

**How can annual meetings of public health nursing services in counties and small towns be planned so as to interest the public and attract a good audience?**

(A summary of former answers to this question)

Personal invitations more effective than newspaper announcements.

Secure 25 women to be responsible for the attendance.

Luncheon or dinner meetings with five to ten minute talks on health.

Speakers of note.

Interesting report of year's work prepared by nurse, supplemented by maps or graphs.

Make statistical part of report brief, and give human interest stories generously but tactfully.

Report from school and county nurse, entertaining as well as enlightening.

Address by president of association telling accomplishments of year.

Reports from committees given in interesting way.

Reports from members of committees representing different districts telling of work done in their section and résumé for coming year.

Address by state worker—director of Bureau of Public Health Nursing, etc.

Moving pictures if available on health subjects. (A list of films may be secured from the National Health Council, 370 Seventh Avenue, New York City.)

Demonstration by little mothers' class.

Health play given by school children.

A blind child, attending State School through nurse's efforts, read Braille before group who had never heard Braille read.

Picnic dinner immediately preceding annual business meeting.

## HOW ONE NURSE ORGANIZED AND INTERESTED HER COMMITTEE

*By Bessie Nicoll, R.N., Formerly Red Cross County Nurse, Hamilton County, Iowa.*

At the door of the finest house in town stood a woman in the well known uniform of the Red Cross Public Health Nurse.

"How do you do, Mrs. Nelson? I would like to talk to you about a little committee I'm forming, if you can give me a few minutes today."

"Well, I've got to be up town at two o'clock to practice our quartet for the Ingleside Club banquet. Tomorrow I'm entertaining the P.E.O. at luncheon and I must go over the whole house before that." The nurse cast her eye over the immaculate hall. "I never was so busy in my life and I certainly can't join any more clubs or organizations."

When she paused for breath the nurse explained her mission a little further.

"Well, come in, Miss Brown. I'll have time to talk awhile."

Inside in the beautiful living room the nurse sank into a luxurious chair and outlined her plans for forming a Nursing Activities Committee in Hamilton County.

"Let me see, Miss Brown, how long have you been here?"

"I've been here a year, Mrs. Nelson, but I've never had a committee to work with me, and you know at the close of the first year there was a question as to whether or not the service would be continued."

"Oh, I didn't know anything about that. In fact, to tell the truth, I really haven't known much about your work. What will we have to do? Will there be much work to it?"

"I may call upon you to assist me in a clinic. That may mean writing histories, or

furnishing sheets and pillows or it may mean helping find the people who need to come to the clinic. I am hoping to begin teaching some classes in Home Hygiene and I may need your help in securing equipment for those classes. I shall want you to help me find the people who are in need of special health work. More than anything else, I want to have a group of people in each community who will understand what the nursing service means and can interpret it to others."

"Well, I'd like to know more about it myself and I'll help you, Miss Brown, but I won't be chairman. Absolutely. I refuse to be the chairman of anything!"

"Thank you, Mrs. Nelson. I'm glad you are willing to serve on this committee. I believe you will enjoy it and I will let you know the date of our first meeting."

As the nurse climbed into her Ford and drove away she thought out loud, "Oh, dear, if I had known how hard it was going to be, I should never have had the courage to go there.

It was Saturday afternoon, the first one in the month of September. The nurse carried another chair into her office and counted them all again. There were eighteen. She wondered how many would be filled. This was the afternoon of the first meeting of the Nursing Committee. Would anyone come? Some of the women she scarcely knew. Many of them would be strangers to each other. She must make them all feel at ease—the timid woman from the farm as well as the wife of the banker of the county seat. And most of all she must get over clearly to them the purpose of this committee. Could she do it? Why did she ever try to organize such a committee anyway? Why not go on as she did last year working alone? It was easier than getting all these women together.

It was June; a group of ten women met on a windy day in a little village park for a picnic lunch. This was the last meeting of the Nursing Committee for that first year. They were taking stock. Had it been worth while? The meetings had not always been well attended, but a meeting had been held each month and there had never been less than five in attendance. Many things interfered—sick children, church programs, farm hands to be fed, incubators to watch, flat tires. Sometimes these women overcame many obstacles to attend. Not always were they able to do so, but invariably their testimony was the same, "I wanted to come. I certainly do enjoy the meetings."

Miss Brown, made confident by the sincerity of this group, said: "How would you like to have a program committee and plan a definite health program for each meeting next year"?

The next year they discussed health topics at their meetings in a systematic manner. Some outside speakers were brought to contribute to the program. Health problems of the different communities were brought up for discussion. . . .

It is June again. Three years have passed since that first small group met in the park. Car upon car arrives at the lake. Men, women and children are gathering here. The children scamper to the water's edge. The men collect in groups until they are commanded by their wives to gather wood for a fire, carry baskets of food from the cars to a long table over which floats a Red Cross flag. Who are these people? What is the occasion? This is the annual picnic of all Red Cross workers of the county who have been brought together by the Nursing Activities Committee. There are almost a hundred of them.

The chairman of this committee rises to speak. It is none other than Mrs. Nelson.

"I want to tell you that while I have always said I would never be the chairman, I have enjoyed being the head of this committee this year. Since Miss Brown is leaving us to go into another field and we shall have a new nurse, what do you people want to do about this committee?"

The members rise one after another and express their willingness to continue serving and be ready to meet the new nurse when she arrives. There is a friendly feeling among this group. No longer are they strangers to each other. The one time supposed jealousy of the small town people and the accused snobbishness of the county seat folks is gone. They are ready to stand by the work though the worker must go.

# REVIEWS AND BOOK NOTES

*Edited by* DOROTHY DEMING

## HANDBOOK ON VENEREAL DISEASES

*By W. Turner Warwick, F.R.C.S.*

Faber and Gwyer, Ltd., The Scientific Press, 24 Russell Square, W. C. 1, London, England.

This little book of 221 pages was written especially for nurses. The author, out of his practical experience in the Middlesex Hospital in London, presents the general and special facts regarding syphilis and gonorrhea with which he believes nurses should be acquainted. In his preface the author says "It is recognized that, by its influence on family life, the nursing profession could be of much more assistance in the fight against venereal diseases than it has been in the past. This book has been written with the object of encouraging all nurses to engage in such work."

The author gives a brief, interesting account of the history of syphilis and gonorrhea. He refers in this chapter to the famous poem by Frascatoro entitled "Syphilis sive Morbus Gallicus" from which it is likely the name syphilis was derived. He tells of Hunter's "proof," by an experiment upon himself, that syphilis chancroid and gonorrhea are manifestations of the disease, an error which was not rectified until 1837.

After discussing the nurse in relation to venereal diseases and the prevalence of, damage done by and cost of syphilis and gonorrhea the author discusses the prevention of these diseases and the methods by which educational and chemical prophylaxis are carried out in Great Britain. An interesting feature of the section dealing with chemical prophylaxis is instructions for early preventive treatment for the female.

A chapter is devoted to the duties of a nurse towards patients having syphilis and gonorrhea and much sound practical advice is given regarding precautions which nurses should take when dealing with infectious cases, the great need for discretion on the part of the nurse, and the legal aspects of diagnosis and treatment of syphilis and gonorrhea.

In Part II the author gives a simple straightforward description of the various manifestations of syphilis and the diagnosis and treatment of this disease. Part III deals similarly with chancroid and Part IV with gonorrhea in the male and in the female, adults and children. In an appendix is given useful information regarding equipment for the treatment of female gonorrhea, the making of stock solutions and an account of certain laboratory tests used in syphilis and gonorrhea clinics. Finally a brief account of certain other skin lesions which may be confused with manifestations of syphilis.

For nurses, public health workers and others who have not medical training this book is recommended. The information, instruction and advice which is given is thoroughly practical and except in a few instances where the text refers especially to British institutions, medicaments or methods, this hand-book will be as useful for American as for British nurses.

WALTER CLARKE, M.D.

## ETHICS AND THE ART OF CONDUCT FOR NURSES

*By Edward F. Garesché*

W. B. Saunders, Company, Philadelphia. $2.50.

The object of this book as stated in the introductory note is to treat of the "Science of Ethics for Nurses," and also to outline some of the principles of the Art of Conduct. The book is therefore divided into Part I, Ethics, and Part II, The Art of Conduct, and

Part III, Points and Papers for Discussion.

It is evident that the author is a religious teacher rather than a student of ethics pure and simple. Authorities are not quoted, no reference is made to other books on ethics, nor are any suggestions for further reading given. Undoubtedly some of the statements and explanations contained in the text will be questioned by the thoughtful nurse.

Part II, The Art of Conduct, discusses in relation to the nurse and her work those principles which one expects the home and the school to teach. Possibly it is necessary today to lay more emphasis on simple rules of conduct than formerly when pupils were older and therefore somewhat more thoughtful. Nevertheless the instruction given is in many cases so fundamental that one is loath to believe that most nurses are not already familiar with it.

The questions and topics for discussion, given in Part III, are planned to be a guide to the instructor using the book as a text.

MARION M. RICE, R.N.

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The American Library Association announces a new booklet in the "Reading with a Purpose" courses. It is on "Mental Hygiene" by Frankwood E. Williams.

The booklets may be borrowed at most public libraries and at the larger ones may be purchased at nominal prices. They are also available in cloth at 50¢ for a single copy or at 45¢ each for ten copies or more. Prices in paper range from 35¢ a single copy to 11¢ each in lots of 100. Send to the American Library Association, 520 North Michigan Ave., Chicago, Ill.

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Public health nurses who are teaching anatomy and physiology to groups will find the revised textbook and outline by Dr. Jesse Feiring Williams (W. B. Saunders Company, Philadelphia, Pa., $2.50) helpful and well illustrated.

*Children, The Magazine for Parents,* changed its name to *Children, the Parents' Magazine.* Not content with the emphasis, however, we note a still better title—*The Parents' Magazine.* We call especial attention to this magazine as a help to public health nurses who may be conducting mothers' classes, or are desirous of suggesting health topics to Parent-Teacher Associations. Special leaflets are available for group study and a special department in the magazine outlines programs for meetings. Address, 255 Fourth Ave., New York City.

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The National Health Library, supported by member organizations of the National Health Council, is issuing a revised edition of its "List of Health Magazines in the United States." The list is divided into three sections—national, state, and local—each giving the names of the more prominent health journals, their editors, place of publication, subscription rates, etc. Price $.10. Address, 370 Seventh Avenue, New York City.

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Programs suggested for use in celebrating Armistice Day, Goodwill Day and Memorial Day, which have the focus of attention placed on heroes of peace and avenues for world coöperation, rather than military achievements, have been compiled by the Education Committee of the Women's International League for Peace and Freedom, and are available upon application to the Women's International League for Peace and Freedom, Pennsylvania Branch, 1924 Chestnut Street, Philadelphia, Pennsylvania.

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Honoring one of our own profession, the Metropolitan Life Insurance Company has issued a new illustrated "Health Heroes" leaflet — *Florence Nightingale.* Every nurse will want to own this readable, carefully prepared story of her life, and will find many uses for it in class work and mothers' clubs. . . . "Her mind was like a sword — hard, sharp, brilliant. Pas-

sionately she used it to do battle for those whom she saw suffering needlessly. Ruthlessly she bared the easy-going inefficiency which hitherto had made a disgrace of sanitation and nursing. . . ."

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Two new and timely pamphlets have been issued by the John Hancock Mutual Life Insurance Company—*Your Heart* and *Your Vacation*. We are a little late in mentioning the latter but the former we have always with us—or we are not! "The healthy heart is a sturdy muscular organ, perfectly able to do its great job, night and day, decade after decade . . ." This leaflet outlines fair and friendly treatment of this most vital of organs.

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The Sayre Foundation Lectures by Dr. C.-E. A. Winslow for 1929 have been published under the title "The Road to Health" (Macmillan Company, price $2.00). As in so much of Dr. Winslow's writing, inspiration, knowledge and new ideas are to be found here. We recommend particularly the last lecture—"The Physician in the Modern State."

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*Improving the Dietary Habits of a Rural Community* is a report of three years nutrition work in Cattaraugus County, N. Y., by Ruby M. Odell, formerly nutritionist of the Cattaraugus County Health Demonstration. Copies of the report may be had from the Milbank Memorial Fund, 49 Wall Street, New York, N. Y. We quote one astonishing sentence: "As the result of a talk the nutritionist made to a group of Home Bureau women on the nutritive value of cabbage, a merchant in one community sold a carload of this vegetable in a week, whereas it had previously required a month for him to dispose of this amount."

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Those interested in the administration of marriage laws in the United States will find *Marriage and the State* by Mary E. Richmond and Fred S. Hall well worth reading. It is published by the Russell Sage Foundation, 130 East 22nd Street, New York City. Price $2.50.

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The New York State Nurses' Association, League of Nursing Education and Organization for Public Health Nursing have issued their first quarterly bulletin called *Quarterly News*. The Publications Committee consists of two representatives from each of the three organizations, Agnes Martin of Syracuse and Marion W. Sheahan of Albany representing public health nursing interests. Miss Sheahan is chairman of the committee. The *Quarterly News* is published in order to reach nurses who do not subscribe for the nursing journals and to keep all nurses informed particularly on the findings of the Grading Committee and intimate state activities.

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Will any reader who has a spare copy of THE PUBLIC HEALTH NURSE for March, 1929, be generous and send it to National Headquarters? Postage will be returned. Our supply for March is exhausted and there are many requests.

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The following numbers of THE PUBLIC HEALTH NURSE magazine may be had for cost of mailing. Please send for them at once.

1922—May-October inclusive
1923—All except January, February and September
1924—Complete
1925—All except August
1926—Complete
1927—All except January
1928—All except February, July, August and September

Address, Miss Helen Scott Hay, 508 Chicago Avenue, Savanna, Ill.

# NEWS NOTES

Announcement has been made by President Hoover of his intention to call a White House conference on child health and protection to be held some time within a year. The conference will be made up of representatives of the great voluntary child welfare associations and of the Federal, State, and municipal authorities interested. Its purpose will be to determine the facts as to present progress and future needs in the field of child welfare. A series of committees will be appointed to make exhaustive surveys of the work now being done for the care and protection of children and prepare reports to present at the conference. The expense of the conference will be met by a gift from private sources. The conference will be under the direction of the Secretary of the Interior, Dr. Ray Lyman Wilbur, with the coöperation of the Secretary of Labor, James J. Davis.

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The German Red Cross has issued a manual for Red Cross committees and rural and district nursing services, containing practical information on the following subjects:

**Organization, administration and functions of a public health center, the duties of the public health nurse, the welfare of the nurse in case of ill-health or old age, and her relationship with persons and organizations with which she is called upon to collaborate.**

An annex to the manual gives a list of furniture and utensils necessary for the equipment of the rural and district nurses' abode, together with a list of articles needed for her work.

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The first Parent-Teacher Association on an Indian reservation was organized recently in school district 6, located between Olean and Salamanca on the Allegany reservation, New York. Miss Edith John, state supervising nurse, made arrangements for the meeting and presided. The Parent-Teacher Association has a well planned health program. If it can be developed on an Indian reservation it will be an innovation which should prove of great value in developing health work among this race.

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The United States Public Health Service has recently issued a report dealing with the extent of rural health service in the United States. On January 1, 1929, 467 counties or districts were provided with whole time health officers.

There are in the United States about 2,500 counties or districts comparable to counties wholly or in considerable part rural to which local health service under the direction of whole-time county or local district health officers is applicable and in which such service would be highly advantageous. The number of these units of population in which such service was in operation at the beginning of the year 1929 was 467, as against 414 at the beginning of the year 1928.

Efficient well-balanced whole time rural health service throughout the United States would cost about $20,000,000 a year.

Money invested for well-directed whole time county health service yields to the average local tax-paying citizen an annual dividend in dollars and cents ranging under different local conditions from 100 to 3000 per cent.

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The Inter-Chamber of Commerce Health Conservation Contest recently launched is an outgrowth of a joint educational service between the Chamber of Commerce of the United States and the Committee on Administrative Practice of the American Public Health Association.

This contest will be carried on among member organizations of the Chamber of Commerce of the United

States. The Committee on Administrative Practice will act in an advisory capacity and upon request from health officers will render free consultant service, within the limit of its resources, to cities entering the contest. The object of this competition is to assist in reducing economic losses in the United States due to unnecessary illness and death, by means of activities carried on through the organization and thence the leadership of health committees of local chambers of commerce or similar associations, in coöperation with the official health agencies.

Entry blanks and details of the contest may be secured from the Committee on Administrative Practice, American Public Health Association, 370 Seventh Avenue, New York City.

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The Treasury Department, Washington, D. C., states that where competent evidence is furnished that (1) the taxpayer actually attended the conventions mentioned, (2) was not reimbursed by any individual, society, or organization for expenses incident to such attendance, and (3) actually expended for the purposes described the amounts claimed as deductions, it is held that the expenses incurred in attending the nursing conventions in question constitute proper deductions in computing the taxpayer's net income for the year or years affected.

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A full-time child guidance clinic has been organized at Indiana University as a result of the demonstration clinic conducted in Indianapolis by the Commonwealth Fund and The National Committee for Mental Hygiene.

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The New Zealand Government now trains girls, aged about 19 upward, of exceptional intelligence and physique, to act as practical dental nurses after a two years' intensive course. At the end of their training these dental assistants undertake the care and treatment of children's teeth in the schools under the supervision of qualified dental inspectors. The work begins with the entrants, 97 per cent of whom are found to need treatment, and follows them up throughout their school life.

The service has the coöperation of parents, teachers and local committees, who in districts where a nurse-operator is appointed on request, make themselves responsible for the equipment and upkeep of her clinic room, her salary being paid by the Government, the Education Authority. — *National Health.*

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Syneve Eikum, a graduate of the Army School of Nursing, has been asked to remain in Brazil and revise their Manual of Public Health Nursing in Portuguese.

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As always, the Red Cross will conduct its nation-wide enrollment of members from Armistice Day to Thanksgiving—November 11 to 28, 1929.

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The formal opening of the new home for the Public Health Nursing Association in Terre Haute took place in June.

The house has eight rooms, every one in use. Downstairs are the general offices with a room for mothers' training and another for prenatal classes. A waiting room is on the lower floor also.

The kitchen at the rear will be used for developing food formulas outlined for proper feeding of children. Classes will be taught there also.

The upstairs floor will be given over to class rooms. A supply room and a caretaker's room will be up there also, and a long room for the nurses' tables.

One room above stairs is dedicated to the Rotary Club, because of the assistance given the association by the Rotarians.